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An Address.[1]

RETROSPECT.

By ALAN B. MCCUTCHEON,

Retiring President of the Victorian Branch of the British Medical Association.

RETROSPECT in this address will be viewed largely within the limits of the growth of the modern branch of medicine now known as gerontology, from its primitive formative years to its near-efficient modern standard. I propose to use the history of Mount Royal, Royal Park, as a kind of yardstick with which to measure the evolution of the new science.

Forty-odd years ago, when I was a student, there was little if any work being done in the direction of promoting the study of the normal aging processes or the diseases and disabilities pertaining to advancing years. Practically nothing in this direction was included in either lectures in the class-room or clinical instruction in the wards. In other words, old age was an inevitable "last lap" in the human race, and the race was not to the swift but to the slow and fortunate oldsters in the community. Those who were of good heredity and constitutionally sound had a better chance of achieving the last lap than those who dropped out of the race prematurely broken down. There was no rehabilitation, and conditions were *laissez faire*—feed them, bed them and treat symptoms as they arose, but nothing more could be done.

Such was the position in mid-1928, when I assumed the duties of medical officer to Mount Royal, at that time called the Victorian Home for Old People. I found that among my prescribed duties was that of dispensing all medicines required in the institution. As I had done my own dispensing for two years in the country, this presented no difficulties, but it did use up time which would have been better spent in purely medical work among the inmates. I put in a recommendation that a part-time dispenser should be added to the staff, and in due course that anomaly was rectified, with an appreciable improvement in the work. There was at that time on the male side one infirmary ward of about 40 beds under the nursing care of Sister Mahoney, who had gained all her experience in Mount Royal, was not a registered nurse, but was thoroughly efficient in both nursing and organization. She later became Matron of Mount Royal and spent many years in that position, and concluded a notable contribution to the care of the aged when she retired at the end of 1956. The late Colonel R. L. Elliott had been Secretary and Superintendent for some three years or so prior to my joining the staff, and to his and Matron Mahoney's indefatigable efforts to improve the standards of nursing and treatment must be attributed

[1] Delivered at the annual meeting of the Victorian Branch of the British Medical Association on December 4, 1957.

the steady advance in the status of Mount Royal to its present position as an institution of approximately 600 beds, which works in liaison with the metropolitan hospitals—especially the Royal Melbourne Hospital—to maintain the care of elderly sick people of both sexes. In addition to structural improvements in the buildings there has recently been added the geriatric unit, to which further reference will be made later. At this point let us go back to the early history of Mount Royal. For the following historical details I am indebted to an article by Mr. A. W. Greig in *The Argus* of August 29, 1925.

Immigrants' Aid Society.

In the year 1852-1853 the population of Melbourne was increased by 104,188 persons, with immigration at its peak and people arriving in the Colony with little or no resources, attracted by the lure of gold.

This rapid increase raised the important issues of accommodation and medical attention, which were met by the erection of "a huge array of tents adjoining St. Kilda Road, then called 'Canvas Town'". At the same time was formed a body called "The Immigrants' Aid Society", with the object of assisting those who had no shelter and those who were sick and/or destitute. A public meeting was called in the Mechanics' Institute in Collins Street (later to become the Athenæum), as a result of which the sum of £8000 was collected and many gifts in kind were also received. Employment, medical advice and medicines were arranged for, and a fever tent (typhoid being prevalent under the primitive conditions) and a dispensary were established. Further building accommodation for new arrivals was added, and by 1856 10,000 people had been granted relief. This aid was first given only to persons resident in Victoria for less than two years, but later was extended to all destitute and/or sick persons. In 1857 further extension was made to include neglected children referred by police magistrates and paid for by the Government. School classes *plus* occupational training were added. By 1863, as the number of these children increased, police barracks on the opposite side of St. Kilda Road were taken over and the children transferred there, the total number then being 426. In 1864 the Industrial Schools for Children housed at Royal Park were formed, and the children were all transferred there.

The original home was now called "The Immigrants' Aid Society for Houseless and Distressed Persons", and provided accommodation for debilitated and destitute individuals not requiring active medical care in hospitals. By 1874 the institution consisted of a women's division on the east side of St. Kilda Road (about where the Queen Victoria statue was later erected), a hospital and "place for casuals" on the west side, and the male division in the police barracks. By 1882 both the land on the east side and the police barracks were required for Government purposes, and the Industrial Schools for Children at Royal Park having been vacated, all male inmates and hospital patients were transferred there from St. Kilda Road. It was not until 1914 that the women inmates were moved to Royal Park, and the institution became known as "The Victorian Benevolent Home and Hospital for the Aged and Infirm" in 1925—quite a long, fantastic game of "put and take".

A few years later—the existing name being considered rather cumbersome—it was renamed "Mount Royal", this being further amended a few months ago so that at present it is called "Mount Royal Special Hospital for the Aged, and Geriatric Research Unit"—a most complicated sum of addition taking 105 years, but always showing a steady and forward progress. Now let me turn the clock back 30 years to a time about which I can speak from personal experience.

Mount Royal Today.

The buildings which were taken over from the Industrial Schools for Children were built in Spanish mission style, with a central courtyard enclosed by two-storeyed buildings divided into four wards (originally the dormitories for the children), and now having an extension on the south end with an administration block on the ground floor and ward and admission block upstairs.

The original purpose of these buildings still reveals itself in the massive bluestone stairs with heavy banisters studded with iron spikes, devised to prevent children from sliding down them, with the risk of serious injury if they fell on the bluestone flags at ground-floor level. The bluestone steps remain unchanged except for the deep grooving produced by half a century of abrasive footwear. The female inmates are housed in a relatively modern building on the north side, divided into two blocks each of two wards of about 40 beds. Five of the male wards were occupied by ambulant inmates, most of whom spent the summer months in rural jobs, wandering the roads as "swaggies", but always at the first cold touch of the changing season coming back like homing pigeons for their winter comforts at Mount Royal. This practice still continues, but on a very much reduced scale. From the medical viewpoint they are not much trouble, and some are given employment either on outdoor staff in the grounds, in the laundry, or as ward orderlies. There is also the inevitable section of intermittent or chronic inebriates who, if paraded to the superintendent, are given one warning; the second offence brings prompt expulsion.

Ambulant and Infirmary Wards.

At present there are four infirmary wards, each of 52 beds, and six wards for ambulant inmates of about 30 beds each, in the men's section *plus* the "Soldiers' Block"—a total bed capacity, including female accommodation, of 610. This represents a great advance on the one infirmary ward which operated just on 30 years ago, and reflects the vastly greater demand for beds for sick people at the present time as compared with then. All inmates with serious medical and surgical conditions were transferred to a general hospital, when possible on an exchange basis. Over the course of the years I have watched the steady increase of applications for admission of really ill old people with a corresponding decrease in the ambulant type. The bed accommodation originally required for the latter is gradually being taken over and remodelled for use by the former, so that in the not very distant future one can envisage the whole place as being used for infirmary patients. In recent years there has been a steady increase in demand for beds, owing to the introduction of workers' compensation and motor-car third party insurance cases, which accounts for the number of inmates noticed going round on crutches or sticks, or lying in bed with plaster casts on their limbs. Our role then is steadily switching over from custodial care to nursing and treatment care.

Treatment.

Methods of treatment have naturally undergone a great change with the modern development of chemotherapy and antibiotics, which of course are of great value in geriatric work as in general medicine; but the science of modern gerontology has opened up new avenues in treating these old people—particularly along the lines of rehabilitation. The application of physiotherapy and occupational therapy, and in a small percentage of cases speech therapy, will play quite a part in restoring mobility to the near bedfast and in restoring also their mental attitudes, particularly their confidence that something is being done to help them. I would question the probability of any substantial rise in the expectation of life, but do expect a great improvement in the attitude of the old people, in that hope and comfort will be maintained and their mental horizons will not be limited to four walls and three meals a day. Arteriosclerosis and arthritis incidental to old age will still be with us, but perhaps not to such a crippling degree as heretofore and with not such a dreary outlook. In this connexion I do deplore some of the *couleur de rose* articles which have been published announcing the "new era" which is impending. I am probably conservative in this viewpoint, but still will welcome any improvement in mental outlook and increased cheerfulness which the new science will bring.

There is still room for some "mental therapy" in the daily bed round. Many new arrivals are despondent and worried—almost frightened about what will be done to them; but if one can explore their interests and discuss them with them at the bedside, it is often quite a help in making them open up.

Types of Patients.

People of almost every walk of life have found their way into Mount Royal beds. I can recall, offhand, one minister of religion, one or two medical men and solicitors, one famous engineer—some of whose ideas and plans are under discussion at present in town planning—one former shipping company manager and two prize fighters of international reputation. One of these last-mentioned (in his palmy days) owned a villa in Potts Point (in its palmy days), and drove round Sydney in a carriage and pair, taking off his hat to his sporting friends. But alas! He was too generous to his friends, and died penniless in Mount Royal. Hard living, hard liquor and hard luck —each played its part in directing a man's last days to Mount Royal as his final residence.

Extra Additions to Accommodation.

In 1937, when the Inebriate Institution at Lara—a Government enterprise—was closed, a new building was erected at Mount Royal, by arrangement with the Board of Management, and put into commission. This was financed by the Government and administered by Mount Royal. After it had functioned for a number of years, the treatment of inebriates was transferred to the Mental Hygiene Department, and the building was handed over to Mount Royal in 1943 to be used for the housing of ex-servicemen. It has proved very useful and popular. Two other buildings were added by request from the Department of Public Health, Tuberculosis Division—one of 20 beds for indigent and infirm male tuberculosis patients, and another near the women's division for similar female tuberculosis sufferers, this one being paid for by the Eleanor Shaw bequest. These were administered by Mount Royal under medical supervision by doctors of the Tuberculosis Division. These units have both been handed back to Mount Royal, and are now useful as intermediate wards at £6 6s. per week.

Amenities.

With the development of the first women's auxiliary at Mount Royal and the opening of a kiosk in the courtyard, the lot of the inmates has been brightened. The ambulant inmates patronize it directly, and the bed patients order what they want and the order is delivered at the bedside by a messenger. All profits are devoted to the interests of the institution.

There is a large concert hall fitted with theatre type seats, easily removable, and a good picture screen and projector box, where pictures are shown weekly to inmates; in addition, various entertainments are given in the hall by visiting parties.

When one adds to these the various organized motor-car runs for those able to go, it is seen that much is being done to lighten the tedium of institutional life, and it is evident that most of the inmates so catered for are contented and happy to remain there.

Incidental Humour.

It is not surprising that with such a variety of types of inmates the lighter side of life shows up often and at least helps the daily round of the nurse and the medical officer. For example:

> A very argumentative old Scot was listening to a discussion on the prospects for the current Stawell Gift. Scotland always has something better than any other country in his philosophy, and he said to me: "Ye talk aboot yer rinnin', ye should have been to Poother Ha' in Edinburgh. Mony's the time A run there when I was a lad." I challenged him to a race up and down the ward for a fiver. He came back at me with: "Aricht, and gin yer no a better rinner than y'are a docther I'll take yer money"—much to the amusement of the neighbouring patients and discomfiture of the doctor. The old man was aged about 85 years and bedridden.
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> Then there was the lachrymose ex-digger, World War I, who frequented the back entrance gate waiting for the undertaker's van to come out with one of the departed. His custom was to pull out his handkerchief, wipe his eyes, and say: "There's another of the old boys gone to his rest." On one occasion he mistook the new garbage van carrying left-overs from the kitchen for the undertaker's van, went through his usual ritual till the van passed him, and added: "But they should have buried him a week ago!"

One more short sample of humour in the home.

> A certain embittered and contradictory inmate would always contradict what the other fellow said. As I passed by his bed one day I heard him hiccup. I stopped and said: "Hullo, got the hiccups?" He glared at me and replied: "Certainly-hic-not!"

Such are a few samples of the saving grace which helps to lighten the day for both inmate and doctor.

A Few Notes on the Geriatric Unit.

During the last five or six years in Australia, and for a good deal longer overseas, much has developed in connexion with the rehabilitation of old people who have become the victims of arteriosclerosis and associated cerebro-vascular accidents, or the other big bad wolf, chronic arthritis. Two new words have been added to the dictionary, gerontology and geriatrics, one being the science and the other the practice of the treatment of old folk. During the last decade an International Association of Gerontology has been formed, and several congresses have been held in America, in the United Kingdom and on the Continent, and tremendous interest has been aroused. I was fortunate enough to be able to attend one in London in 1954, and the total number of delegates was 736. The late Colonel Robert Elliott, to whom I have referred earlier, also visited overseas and attended a congress and carried out much research there on the administrative side, but unfortunately did not live quite long enough—by four months or so—to see the unit at Mount Royal officially opened in October, 1957. He had discussed with Dr. J. H. Lindell the question of a unit at Mount Royal run in conjunction with the Royal Melbourne Hospital, and had sought the approval and cooperation of the Hospitals and Charities Commission. Dr. Lindell was strongly in favour of it, and gave encouragement for the belief that Mount Royal would have the first purpose-built geriatric unit in Australia. The Board of Management, Mount Royal, discussed the question and gave its approval subject to financial cooperation and approval by the Hospitals and Charities Commission. As you are aware, the project marched on, and the building was commenced and finally was officially opened in October, 1957, at an over-all cost of £195,000 fully equipped. It has a bed accommodation of 76. The nursing staff is fairly complete, but the physiotherapy and occupational therapy side are not working to full extent owing to shortness of staff. We hope that will be remedied after the end of the year with new graduates coming in.

The appointed geriatrician to the unit is Dr. R. F. Butterworth. He is still overseas, but should be taking on his job early in 1958. His overseas trip was generously sponsored by the treasurer of Mount Royal, Mr. James Ross, who gave the money for the bursary which is financing Dr. Butterworth's trip.

The patients who will be admitted to the unit will come on recommendation from the geriatric research officer at the Royal Melbourne Hospital, and treatment will be applied over a trial period. Those not responding will possibly be drafted back into Mount Royal. The year 1958 will show how the unit will function when its gets into its stride. Great things are expected of it, but we do not expect any miracles—only satisfactory response to the work put into it.

Finis.

This somewhat rambling paper has, I hope, traced a chequered development from very primitive beginnings, through a steady evolutionary process over a period of over 100 years, into a fine, busy institution. It promises to do much for old people in this community, and to make them realize that a strong, friendly and skilled effort will be concentrated on their welfare, to rehabilitate them physically and mentally and to help them to realize that they are still approved members of society and not just drifting old hulks.

The words from Browning's "Rabbi Ben Ezra"—"Grow old along with me, the best is yet to be"—are perhaps somewhat hackneyed, but could be fittingly applied to the evolution and development of Mount Royal in its 100-odd years of service, and might well be adopted as its motto.

"COMPREHENSIVE MEDICINE": A REVIEW OF UNDERGRADUATE MEDICAL EDUCATION.

By NEVILLE G. SUTTON,
Dean of the Faculty of Medicine, University of Queensland.

> Consider that I laboured not for myself only, but for all them that seek learning.
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> (Apocrypha, Ecclesiasticus, XXXIII: 17.)

To my mind, these words from the Apocrypha sum up the life work of Errol Meyers. His memory is to be cherished for the great contribution he made to medical education in Queensland. He played a most important part in the establishment of the medical school in the University of Queensland.

This school undoubtedly had its beginning in the development of dental instruction. Meyers taught anatomy to dental students by means of dissections at the small, unpretentious building in William Street, which was acquired in 1927. To make this possible a special *Anatomy Act* was necessary, and Dr. J. V. Duhig was one of those whose representations to the Government of the day brought this to pass. Teaching of pathology to dental students by Dr. Duhig himself followed.

It was Dr. Meyers who was instrumental in securing the services of Mr. E. Bagnall, from the Department of Anatomy in the University of Sydney, as his chief technician. "Ernie" Bagnall has remained with us in this capacity ever since, and like many others in widely scattered schools, he has become the *genius loci* of the Department of Anatomy, and is much honoured and beloved by us all.

After the School of Medicine had been established in 1936, Meyers continued to play an important part in its further development. He also continued his teaching in the Department of Anatomy in the Alice Street building, the first home of the department, was the lecturer in surgical anatomy and operative surgery in the Department of Surgery, and continued his Wednesday morning classes in these exercises until 1955, when ill-health compelled him to desist.

In 1942 he was elected Dean of the Faculty of Medicine, and carried out the exacting duties of this office until he found it too arduous and relinquished the post in 1953. Throughout these eleven years he became an authority on medical education; he corresponded with prominent medical educationalists throughout the world and wrote numerous articles and letters to the medical Press advancing his views. In 1944 he also assumed the responsibility for the Department of Social and Tropical Medicine, as it was then, with the title of acting professor. His interest in preventive medicine and in the development of a wider outlook in medical education was of a truly pioneering character.

Thinking thus of Errol Meyers it was natural that I should turn to medical education as a theme for this address, and that I should attempt to present the widest view of medical practice, such as is envisaged in the term "comprehensive medicine".

In my medical lifetime constant effort has been made to determine the best methods of training and educating young men for the practice of medicine. So much has been written, so many experts, committees and conferences have pronounced on the subject, that an historical review of the developments during the past 30 or 40 years is quite out of the question on such an occasion as this.

However, there has emerged a definite formula for dealing with the subject, which is now usually followed. This was well enunciated by the late Sir Lionel Whitby in 1953, in his presidential address to the first World Conference on Medical Education. He said:

> In preparing for any calling, there are challenges from three directions. These are directed at the teachers, at those they teach, and at what they teach.

[1]The E. S. Meyers Memorial Lecture, delivered at a meeting of the Queensland Branch of the British Medical Association and the University of Queensland Medical Society on July 19, 1957.

To put this briefly, we are concerned with three aspects of medical education—the students, the teachers and the curriculum. I wish to discuss each of these; but I must confess that little of what I have to say is entirely original. I am attempting to put before you my interpretation of the most authoritative opinions on these matters, some of which have been expressed in quite recent years, others by notable thinkers of the not distant past, whilst some again are as old as recorded history.

Who are they, then, that should be privileged to enter the medical profession?

In this State they are those who reach a certain standard in an examination at the completion of their secondary education and, signifying their desire to study medicine, successfully complete the prescribed courses and pass the prescribed examinations conducted by the university.

In almost all other parts of the world a selection of those who apply is made at the commencement of the medical course, so that only a definite quota is admitted. The quota is fixed by considerations of accommodation and teaching staff, on the premise that only this number of students can be efficiently trained.

This is a sound principle, even though in practice it debars many young men from their opportunity to become doctors. In the United States of America, in the last few years, the number of vacancies in schools was just under 50% of the applicants. In London an exact computation of the number of applicants is difficult, because of the practice of making multiple applications to the 12 medical schools of the University of London.

Selection is usually made by a series of eliminations, first on the record of the student, probably the scholastic record, then on the references and reports, and finally by personal interview. It seems to be extremely doubtful whether selection by interview is very reliable, or at least any more reliable than the examination results.

In some places aptitude and intelligence tests are used, but these again are not held in very high esteem.

Sir Lionel Whitby, whom I have already quoted, also said:

> It is not very difficult to draw a brief pen-picture of the ideal medical student; cultured, broadly educated in humanities, intelligent and intellectual, of transparent integrity, humane and sympathetic, and, above all, one who will love his profession as well as his fellow men and all their weaknesses, their joys and their sorrows.

Few could fulfil such a high conception of student character, but, as he adds, all students should possess at least some of these qualities. I feel sure that many of our students, at the end of their course, are really imbued with the fundamental spirit of this ideal, but many of them develop this only during their six years' course. The difficulty is to know, at the start of the course, who are those that possess such potentialities.

At least, I think it can be affirmed that we are better off than the American schools at the beginning of this century, when it was said that the medical student of this period was likely to be the "one son in the family thought too weak to labour on the farm, too indolent to do any bodily exercise, too stupid for the bar, and too immoral for the pulpit". This withering comment was quoted by A. E. Severinghaus, of Columbia University, in discussing the selection of students at the same world conference.

I discuss these matters because the first-year enrolments in Queensland for 1957 are 169, which is the greatest number we have ever had. The post-war peak of 166 in 1947 was the previous record. Of these 166, no less than 53 failed in their first year examination, which is almost 32%. Perhaps this was an unusual year in respect of examination ability, there being so many returned soldiers who had interrupted their academic study for the grim activity of warfare.

In 1956 there were 142 enrolments in first year, and 33 failed at the end of the year—that is, 23%; but in the second year in 1956 there were 114 enrolments and 39 failed—that is, 34%; and in the third year the figures were 81 enrolments with 23 failures—that is, 28%. This indicates a very considerable failure rate in the first three years of the medical course.

Whilst I think that selection by examination pure and simple is probably just as efficient as other methods, I cannot help deploring the apparent waste of time and effort, not only on the part of students, but also of university staff, that this high failure rate entails. There is even more than this; the overcrowding—and such high enrolments undoubtedly involve overcrowding—must interfere with the efficiency of the university teaching, so that not only do the weaker students suffer, but the good students are also penalized.

In consequence, if we are to continue with an enrolment limited only by a rather low matriculation standard, and its inevitable sequel of a high failure rate at the end of the first, second and even third years, I think that some effort should be made to turn the one or two years' training in science, which the 30% of failing students receive, to some account. In Russia there is a scheme for directing such students, who fail in their pre-clinical years, to a less ambitious course, so that they may become laboratory assistants or technicians. It goes by the persuasive title of "intellectual salvage". Such a step would probably be difficult to achieve with the Australian student who has started a course with high ambition, hoping to become a medical practitioner; but at least I consider that these students should be definitely directed to the Students' Advisory and Guidance Board, which on this occasion should include the Dean or other representative of the Faculty of Medicine.

The reasons for students' failure to pass examinations have not been extensively discussed, but an inquiry was made at the instance of the Vice-Chancellor some years ago in the University of Queensland. I suppose most people, asked their opinion on this question, would dismiss the matter with some statement that it was a poor year. And indeed, I do consider that in a great many cases it is the student who is at fault. The actual reason for his failure may be varied; in their first year many students fail to realize that university study demands a self-imposed discipline. Other causes may be waning interest, lack of application and external distractions.

But on further consideration, there could be three factors involved in a high failure rate. First, of course, there is the lack of ability on the part of the student; secondly, the teaching staff may be relatively inefficient; and lastly, the examination tests may not be well correlated with the course of study presented to the student.

To decide exactly what part each of these factors plays in, say, the high failure rate in the first or second year of the medical course would require extreme wisdom. It is usually assumed that the standard required by the examiners is well considered and that most of the failures are justified.

I think many are slow to realize that true education implies active effort on the part of the student, and a passive attitude, even though it be keyed on a highly receptive note, is not sufficient; hence the great popularity of typescript notes prepared by the labour of the lecturer, whereas the student should prepare his own summaries and annotations to the text-book.

But let me pass on to a brief consideration of the teachers. There is again no doubt that a lengthy and profitable discussion could be undertaken on the subject of the teaching staff of a school of medicine.

Since the publication of the "Report of the Inter-Departmental Committee on Medical Schools" in 1944, known briefly as the "Goodenough Report", all the provincial medical schools in Great Britain and most of the London schools have whole-time professors in each of the departments of medicine, surgery and obstetrics and gynæcology. A number of these are of post-war vintage. The medical schools of Australia have been slow to follow their lead. In Sydney alone have there been whole-time professors of medicine and surgery since 1927; but in the last five years all the Australian schools have instituted chairs in medicine, and the Melbourne school and the new school in Perth in surgery also. In all schools except Brisbane and Adelaide are there full chairs in obstetrics and gynæcology. I think it is generally recognized that such chairs are necessary for the realization of the highest standard of medical education.

In such fully developed departments research activities should be going on, and this is one of the major factors in favour of their institution. The functions of a university include not only the fostering and propagation of human knowledge, but also the constant endeavour to add to this knowledge. This is what research implies, although I must admit that a number of activities which are dignified by this almost magical name really amount only to a rediscovery of knowledge previously unknown merely to the inquirer and his immediate circle.

However, it should not be forgotten that all who have thought about the matter of university departments emphasize the fact that, as the Goodenough Report puts it, "their primary function, in our view, should be the organization, direction and conduct of teaching, that is to say, the teaching of medical students". John McIntyre, Principal of St. Andrew's College within the University of Sydney, speaking in respect of university teaching in general, said last year: "The plain fact of the case is that teaching is the supreme responsibility and privilege of any department, and that everything in the University must serve that purpose." I emphasize this point because I have been led to believe that some departments look upon the task of teaching medical students the essentials of pre-clinical science as rather burdensome. Nothing could be further from the truth. It should be the aim and ambition of every department to interest the students entrusted to its care in the subject professed, and to endeavour to instil in them a firm grasp of the principles and the fundamental truths of this, without overburdening them with too much detail or expecting them to memorize a mass of facts which are, alas, only too quickly forgotten.

The true teacher has an enthusiasm for his subject, but he must not allow his enthusiasm to run away with his judgement. He must attempt to make the subject appear clear, logical and of easy comprehension, and not blur the outlook with too much detail. There is, of course, an art in teaching, and much can be learned from those who are qualified in this respect.

In 1946 the University of Queensland Post-Graduate Committee organized a course of lectures on "Teaching Methods". These were given by two lecturers from the Teachers' Training College, Dr. J. C. Greenhalgh and Mr. C. M. B. Van Homrigh, and by a distinguished visitor in the person of Professor G. S. Brown, the Professor of Education in the University of Melbourne. The whole course was excellent and most inspiring, and I think should be repeated from time to time, so that younger members of the teaching staff can have the opportunity of gaining, from those who have studied teaching methods extensively, at least the fundamentals requisite for good teaching.

I should like to say a few words about the place of lectures in the medical curriculum. This is again an interesting topic and has been repeatedly discussed by both teachers and student bodies. Systematic courses of lectures have been severely criticized by both of these.

It has been well stated that lecture courses which merely present the facts that can be read in text-books are a waste of time. I am afraid that students are still far too frequently inflicted with such courses. However, there surely must be a place for lectures, well prepared, which glean the best from current medical literature, arrange this material systematically and attempt to correlate it with the knowledge already acquired by the students. In fact, lecturers should select, clarify and illuminate the subject matter, and if their technique is adequate and their enthusiasm apparent I think the students cannot fail to benefit. Most branches of medical knowledge are rapidly expanding, text-books are out of date by as much as three years when they are published, and there can be no doubt that there is ample scope for courses of lectures given in the spirit I have indicated.

There is another aspect of medical knowledge which needs stressing. It has been very clearly expressed in recent years by such eminent medical educationalists as Sir Harold Himsworth, the Secretary of the Medical Research Council, and A. E. Clark-Kennedy, late Dean of the London Hospital Medical School. Both emphasize the fact that in the last hundred years medical knowledge has grown so vast that it is quite beyond the powers of any

one man to be conversant with more than a small fraction of it. What is urgently needed is that this knowledge should be organized and integrated. This is a task worthy of the highest endeavours of all teachers of clinical medicine. Their lecture courses should be based on this underlying principle.

Perhaps the most intriguing and most controversial of the three aspects of medical education that I initially propounded is the matter of what should be taught—that is, the curriculum. I am sure that it is time for me to attempt to justify the title of this address, "Comprehensive Medicine". As a matter of fact, I had been disturbed by several suggestions concerning the curriculum of the Faculty of Medicine without being able exactly to define the cause of my perturbation, when I was arrested by a sentence I read in a book entitled "The Valley of the Kings". It is a most interesting book about the discovery of the remains of ancient Egyptian culture, written in 1957 by a German archæologist, Otto Neubert. Right at the end of this book he writes: "The age of humanity has not been able to develop because it has been strangled by the age of science."

I thought of widespread claims being advanced that medicine was fast becoming an exact science, that it appeared within attainment that disease in man could be diagnosed by laboratory tests and treated by appropriate remedies with the precision of a biochemical reaction. This coldly scientific conception really chilled my spine. I conjured up the vision of rows of beds in an austere medical ward, each bed containing a specimen of *Homo sapiens*. Probably the distinguishing adjective "*sapiens*" would be rather unwarranted, as the specimens would have their frontal cortex disconnected from the more primitive diencephalon by neo-schizo-eirenegen, the newest and most potent tranquillizing drug, and so be in a state of fatuous acquiescence. The specimens would all be submitted to the full battery of biochemical tests and the treatment then obtained by use of the very latest electronic computer, no diagnosis being necessary. In those few cases in which the answer obtained was "no treatment available" or perhaps "try cortisone", the patient would be kept under the influence of the drug I have just referred to. Country hospitals would have direct connexion by teletype with the central electronic brain, but would be equipped with the latest medical slide rule in order to treat minor conditions locally. Perhaps I exaggerate; but I have further evidence that there are others beside a German archæologist who think similar thoughts.

Recently, in discussing the propriety of acquainting students with general practice as a way of life, Walter S. Wiggins of the United States of America quoted the 1952 Report of the Commonwealth Fund, as follows:

> Medical education may now be in the second of three phases of adjustment. The first . . . has had scientific medicine as its objective and slogan, specialization as its dominant pattern, and the university medical centre as its preferred instrument. The second, now unfolding, is a phase of transition, in which the concept of comprehensive medicine is beginning to modify the definition of scientific medicine, in which there is some reaction against the extremes of specialization, and in which a few medical centres are beginning to re-examine their functions and achievements . . . It is reasonable to hope that it will be followed by a third phase in which there will be some reconciliation between what has been called "scientific medicine" and what is now called "comprehensive medicine" . . . and some reconstructing of both medical education and medical care to fit the needs of a more knowledgeable social order . . . Scientific medicine . . . based on the fullest and most exact knowledge of the patient that is available . . . has hitherto been weakest in relation to the patient's affective life and his social environment.

All this does not imply that I am in favour of a lower grade of scentific instruction for medical students—far from it. I have no sympathy whatever with those who would maintain that in the curriculum only such matters should be included as are likely to prove of direct use to doctors in practice. Not so very many years ago this attitude was rather widespread in our midst, and was sponsored by a number of those in high places.

My opinion of this contention is now as it was then—that it is an extremely bad principle to orientate the curriculum to the requirements of any particular type of practice. Advances in medicine in all fields in the last two decades have been rapid and in many cases spectacular, and it seems reasonable that further advances will continue. Who can say which particular part of the basic sciences will be needed to keep pace with such advances? Even general practitioners might expect that their undergraduate medical course would so equip them that they would be able to read medical literature intelligently for at least 10 to 15 years. It must also be realized that for a majority of medical practitioners their medical course is the only full course of scientific training they ever have.

So, no more of such talk—it is the first step in the debasement of medicine to a mere technology. The teaching in these departments must be maintained on the widest possible basis.

It has been proposed by the newly formed College of General Practitioners, that a general practice teaching unit should be attached to the out-patient department of the teaching hospital. I do not agree with this idea, as I consider that a large general hospital is not the place where any worthwhile imitation of the conditions and conduct of general practice can be represented to students. Rather than general practitioners wishing to come into the hospital, they should do their utmost to try to keep their patients out of the hospital so far as is consistent with the patient's well-being. They should progressively combat the idea that a big general hospital is the place to which to apply for all medical advice. The rising costs of hospital maintenance emphasize this point, and I think it is high time that this extremely costly form of medical treatment should be reexamined and that the advisability—nay, even the advantages—of home care for many patients who now fill hospital beds should be seriously considered.

It has been stated on a number of occasions that it cannot be expected that the role of the general practitioner is to contribute significantly to the students' fundamental medical knowledge. Indeed, W. G. O. Butler, the Chairman of the Undergraduate Education Committee of the College of General Practitioners of Great Britain, in his 1956 James Mackenzie lecture, made the following statement: "It follows that the student—whether he is to be general practitioner or consultant—must be taught the various branches of medicine by the specialists. But—and it is a big but—he must be given a much broader view of disease than is possible in hospital alone."

The real problem is how this latter aim is to be accomplished. In the first place I do not consider that clinical teaching as it is carried out in the later years of the course is entirely satisfactory. With us it is to a large extent in the hands of the visiting hospital staff—that is, a part-time staff, paid on a sessional basis by the Hospitals Board. Teaching is, in the main, carried out in conjunction with ward rounds and out-patient clinics. On these occasions the clinician has to examine the patients placed under his care, confirm a provisional diagnosis or not infrequently correct it, and decide on the treatment. If he has a considerable number of patients to see, with a fair proportion of new cases, his responsibilities are quite onerous and his teaching in consequence is not always adequate. The University of Queensland pays him a small annual fee for this teaching, but it really can be considered merely a token payment. I think there can be no doubt that his first duty is to his patients, and in spite of registrar supervision of the ward work of the junior resident staff, he must be extremely alert and careful in order to avoid the mistakes which can readily occur.

This is not in any way a criticism of the senior or junior resident staff; they have not had long experience, and it is obvious that such supervision is the very essence of the duties of the visiting clinician. The students undoubtedly learn quite a lot from their observation of his work, and he can think aloud, as it were, and so give them a good insight into clinical methods. Of course, the students have the new patients allotted to them and in most cases themselves record their histories and examine them. But my point is that there is not sufficient time available on such a round to do justice both to the patients and to the students. Thus it frequently happens that one or the other suffers. This more or less confirms the criticism voiced by Abraham

Flexner of the British system of ward teaching, in his classical work "Medical Education", published in 1925. He wrote: "The attending staff of the English hospital could not, indeed, visiting the hospital a few times a week, study cases thoroughly, even if training and facilities were adequate."

Nevertheless, I think that such clinical ward teaching is valuable, and it should not be entirely taken over by a full-time professorial department. After all, in the future there will be an increasing number of the staff of such a department who have never seen a patient outside a hospital, and this must limit their outlook at least in respect to the real conception of comprehensive medicine.

This aspect of teaching was discussed at a meeting of the professors of clinical departments of the Australian medical schools held in Melbourne in May, 1957, under the chairmanship of Professor R. H. Lovell, Professor of Medicine at the University of Melbourne. As a result of lengthy discussion, this meeting came to the following conclusions:

1. Whatever the future development of the clinical departments may be, the members of the hospital visiting staff will still continue to carry out the bulk of the clinical teaching.

2. Teaching and clinical duties are frequently associated but they involve different exercises and each requires sufficient time for its proper performance.

3. The honorary system of staffing of hospitals is the usual one in Australia[1] and under this system the staff could not reasonably devote more time to teaching than at present. In the event of the institution of a paid staff, the staff required will be based on the needs of the hospital, and the universities will have to pay the staff for their teaching. In order to improve teaching standards, the universities have to face this increased expenditure.

4. The payment for such teaching is at present purely a nominal amount and since it is clear that the teaching effort will continually increase, an adequate and realistic salary will have to be paid by the universities. The teaching duties should be clearly distinguished from the duties of caring for the patients.

These statements sum up the position very clearly and I think that steps should be taken to rectify the position and to see that the patients, the students and the doctors receive their due.

Such an adjustment would necessitate the visiting staff undertaking an increased number of ward rounds, some of them without students, others specifically teaching rounds. I am, of course, aware that this practice has already been carried out by our physicians, who do one round a week without students; but I am not convinced that it has been sufficiently recognized, and certainly the University of Queensland has not shouldered its responsibility. If it was to do so it could insist on more effective clinical teaching. Not only would the teaching be improved by the opportunities for the visiting clinicians to undertake a more thorough and more systematic study of the patients, and in consequence a more scientific approach to their illness, but a better appreciation of their personality and background would be gained.

That there is need for the latter is evident from the recent writings on medical education. (However, I cannot admit that it is only a general practitioner who is capable of courtesy, kindness and sympathy toward the sick person under his care.) Although this would allow students to be given a considerably wider outlook on the sick patient as an individual with his many personal problems, he would, of course, still remain a hospital patient divorced from his home surroundings and his general background.

As I have already stated, I fail to see in what way the introduction of general practitioners into hospital as student instructors can supply this background. The only way in which this can be achieved is by sending the students to the general practitioners. This practice has been introduced in many medical schools in many parts of the world, and it is still the subject of criticism by some of those interested in teaching. They ask whether it is necessary to give the student during his undergraduate course this brief view (it is at present no more than a few weeks) of general practice, and what is accomplished thereby.

However, I believe the majority favour this innovation and have given many cogent reasons for its adoption. These have been admirably summed up in the statement of a preceptor, quoted by George A. Wolf, junior, in respect to the preceptorship system, as this practice is called in the United States of America:

> The major objective of a preceptorship plan is to learn the so-called art of Medicine in all its ramifications. This includes not only the relationship between the doctor and his private patient, especially in office and home practice, but also acquiring an understanding of the doctor's role among the families and communities with which he is linked, the economic and social circumstances of the population as it affects their medical needs and a host of other intangibles which relate to the proper practice of Medicine. Perhaps it is not too much to suggest that such sympathetic awareness is among the factors distinguishing a true doctor from a student or a physician from a scientist.

This same preceptor makes another most acute and relevant observation:

> It may well be true that in many respects the general practice preceptorship is more important to the man preparing for a specialty than for those whose life work will be in this field.

In a full and critical discussion of the value of this system as conducted in the U.S.A., Wolf remarks:

> It is apparent that bedside, hospital oriented medical teaching cannot prepare completely the physician to deal with the problems occurring in the home and the community.

This is, of course, the crux of the matter; but our present practice can hardly be considered to fulfil the desideratum of Butler—namely, to give the student a broader view of disease than is possible in hospital alone. At present, as I have stated, our students can be attached, on a voluntary basis, to a general practitioner for two weeks during the long vacation at the end of their fifth year. It appears to me that this is too short a period, and during the last long vacation only 36 out of a possible 72 took advantage of the opportunity. I think the whole matter requires further discussion.

The College of General Practitioners is, of course, exerting its influence in whatever direction it is possible to promote general practitioner teaching; but I think that in certain respects its proposals are not quite in accord with the most recent ideas and definite pronouncements, even those from the College itself.

It can no longer be seriously maintained that the training of medical students should be conditioned by the assumption that they are to become general practitioners. The proposal that students should be given an opportunity to be associated with a general practitioner, or to be taught by one, should not be based on these grounds at all. In reality, such a proposal is an attempt to achieve a wider training for students—that is, to achieve the aim of a training in comprehensive medicine.

There are several good reasons for some such training. The chief ones are, to my mind, the opportunity offered of appreciating the difficulties of diagnosing some serious acute diseases and many chronic diseases of insidious onset in the earliest stages, of gaining experience in the general management of various minor, but nevertheless very prevalent and often troublesome, conditions, and lastly of seeing patients in their own home environment and observing the relationship between this and their illnesses.

In fact, there is great scope for clinical, sociological or statistical research in this field. If any one fails to appreciate this, let him remember Sir James Mackenzie of fifty years ago, and William Pickles of today—what they accomplished, and the fine recognition they received from the world of medicine.

And so I think that to be of real value any general practitioner teaching or preceptorship system should be highly organized, of longer duration and compulsory.

The students we train, whether they are to become general practitioners, specialists or public health officers, need a wider general education than we are at present

[1] In Brisbane, of course, this is not so.

offering them, and they should, both by precept and by example, be helped to acquire a better understanding of human nature.

Our aim should be to produce good doctors. The great majority of our students start their course as callow youths of 17 to 18 years, they mature to manhood during the ensuing six years. Their environment must play an important part in the development of their character. We have a weighty responsibility in respect of this aspect of their development and I wonder whether we are sufficiently aware of this.

Conclusion.

I have discussed the three aspects of undergraduate medical education quite selectively, and am conscious that there are many questions that I have omitted; but in the time available I have tried to expound my view on those aspects of medical education which appear to me to be most urgent.

Errol Meyers wrote several articles on this subject, and in emulating his example I wish to express the sincerity of my admiration for his work in the establishment and advancement of the Medical School of the University of Queensland. There is no doubt that his name will ever be remembered with gratitude. I feel sure that the institution of this memorial lecture will afford an opportunity in the future for many speakers more eloquent than I to express similar sentiments to students of a much more highly organized and, I hope, more famous school of medicine than we have so far developed.

As J. R. Lowell, the American poet, wrote:

> New times demand new measures and new men;
> The world advances, and in time outgrows
> The laws that in our fathers' day were best;
> And, doubtless, after us, some purer scheme
> Will be shaped out by wiser men than we.

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MEDICAL EDUCATION AT WESTERN RESERVE UNIVERSITY, CLEVELAND.

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THE experiment in medical education at Western Reserve University School of Medicine, Cleveland, Ohio, has attracted world-wide interest. It has been described in detail by members of its own faculty (Wearn, Ham, Patterson, and Caughey, 1956) and critically discussed by outside observers (Sinclair, 1954; Ellis, 1956).

We have recently participated in the teaching programme, one of us (W.C.B.) as Instructor in the Departments of Medicine and Preventive Medicine, and the other (I.S.E.) as a Fellow in the Department of Medicine.

Clinical teaching is centred in the School of Medicine and associated University Hospitals, but it is also undertaken at the Cleveland City Hospital, and at the Crile Veterans Administration Hospital, which resembles an Australian repatriation hospital. The University Hospitals are an integral part of the School of Medicine and have no counterpart in Australia. The general, obstetrical, pædiatric and psychiatric units are within the grounds of the Medical School. The staff is appointed by the trustees of the University. Their activities are directed towards patient care, undergraduate and post-graduate education, and particularly research. The Department of Medicine at the general hospital consists of approximately 100 beds under the direction of the Professor of Medicine. Each ward of approximately 25 patients is staffed by two interns (house physicians), a resident (registrar), and attached students. Specialist consultative services are provided by sub-departments within the Department of Medicine, and each of these has its own director, full and part-time faculty members, fellows (lecturers and demonstrators) and residents.

THE NEW CURRICULUM.

Origins.

At the end of World War II many young men were appointed to new and vacant positions in the University. Two-thirds of the 27 professors on the faculty staff were appointed during the seven post-war years, and new heads were appointed in 11 out of 13 departments. This young faculty was dissatisfied with many aspects of traditional medical education, and held many discussions in an attempt to formulate and clarify new ideas. In 1950 a full-time professor, Dr. T. Hale Ham, was appointed chairman of the standing committee of the General Faculty concerned with medical education. A revised curriculum was soon established, the first class commencing in September, 1952, and graduating in July, 1956.

General Plan.

The four-year course has been divided into three phases, in each of which there is a correlation of the material from different departments in the teaching of a subject (Table I), and also of basic science and clinical medicine. Phase I begins with a six-week discussion of the structure and function of the cell. Subsequently the organization and function of the various tissues and organs of the body are studied by systems. Basic anatomy is introduced by the dissection of the mature human fœtus, and the relationships of major structures are observed at the same time as their physiology and biochemistry. During the second semester in medical school, the student is introduced to clinical medicine by instruction in physical examination. The syllabus is so arranged that, for example, while the student dissects the heart and great vessels of the fœtus he receives instruction in their histology and in the physiology of the cardio-vascular system. Simultaneously he is given practice and instruction in the clinical examination of this system.

Phase II occupies one and a half academic years, and comprises the study of the principles of medicine and the anatomy of the adult cadaver. After introductory lectures, each system is dealt with from a combined pathological and clinical aspect, so that morbid anatomy, pathological physiology and biochemistry, pharmacology and therapeutics are considered concurrently. Patients who illustrate disease processes under discussion are freely introduced during lectures and demonstrations. "Multidiscipline" laboratories have been specially designed for both Phase I and Phase II students so that they can carry out practical work in various subjects at the one bench. These laboratories are always open to the students, who may continue their practical work in their own time, and also use adjacent desk space for study purposes.

Phase III is mainly devoted to clinical work in the wards, out-patient departments and laboratories. There are no formal lectures. The student's work is supervised and graded by a preceptor (tutor), who is responsible for the correction of his case histories, and who also submits a personal report on his progress to the faculty. During this phase it is mandatory for the student to spend four months in the general wards performing a "basic" (i.e. intro-

TABLE I.

Plan of the Western Reserve Medical Curriculum.

WESTERN RESERVE UNIVERSITY
School of Medicine

PHASE 1 Normal Biology of Man		PHASE 2 Principles of Medicine			PHASE 3 Clinical Medicine		OBJECTIVE
	Projects 1 day / week	Phase 2A	Projects 1 day / week	Phase 2B	Bioclinical study sections	Thesis	Scientific method
Cell biology* Tissue biology neuro-muscular Cardiovascular respiratory Metabolism Endocrine Correlation and review	Anatomy on infant cadaver	Introduction to disease Infectious disease Chemical agents Cardiovascular disease Respiratory Hemopoietic Gastro-intestinal system Urinary disease Male genitalia Skin	Anatomy on adult cadaver (three semesters)	Locomotor system Nervous system Ophthalmology Female genital disease Endocrine, metabolic disease Legal medicine, psychiatry 1 hour per week	Required Basic clerkship Medicine or Pediatrics Ambulatory clerkship Group clinic Obstetrics and gynecology Basic surgical clerkship (Vacation)	Months 4 2 2 2 2	Biologic and clinical sciences
*Biostatistics Introduction to library first three weeks							
Preceptor No. 1 Infant and family		Preceptor Nos. 2, 3 Clinical method			Preceptor No. 4 Continuity Program		Thinking as a physician
Free Time One and one-half week days are free					Electives 4 months Clinical Teaching Research Biologic science		Self education
First Year		Second Year		Third Year	Fourth Year		

ductory) clerkship, and here the fundamentals of clinical medicine are learnt. He must also spend two months in each of the following services: surgery, obstetrics and gynæcology, and a special out-patient clinic described below. The student may utilize the remaining six months in a period of two months' vacation, and four months of elective subjects. He may work in any of the clinical services, general or special; he may assist in teaching, or he may work at a research project. He may undertake special work, such as a clerkship in another university. This range of elective work in the final year of the course is considered to be an important feature of the curriculum.

Special Teaching Facilities.

The Family Clinic.

Early in Phase I each student is allotted as a patient for study a woman nearing the end of pregnancy. The student attends the delivery of the infant and follows its subsequent development, as well as the related medical history of the mother and the remainder of the family, throughout the four years of medical school. This continuous association with a family provides a means of studying the normal physical and psychological development of children, and the influence of social, economic and family factors on the health of individuals. Case reports on the family are written after the first and second years, and at the end of their course students are required to write a summary of their experiences with the family, as well as a critical assessment of the value of the family clinic and its operation.

The Group Clinic.

The Group Clinic is another special clinic in the out-patient department and is conducted primarily for clinical teaching. Each student spends two months of Phase II in this clinic, which is staffed by sufficient doctors to provide intensive supervision of each student's finding on every patient. The student not only takes the history and examines the patients attending the clinic, but also performs the simpler laboratory investigations himself. He spends four half-days per week in this clinic, and during the two months will study about 20 patients. He presents the case to an instructor, suggests the treatment and makes arrangements for more detailed laboratory investigations and requests the opinion of specialists who are readily available. A surgeon and a psychiatrist are in attendance at every clinic, and all other specialists are on call.

The Continuity Clinic.

The Continuity Clinic is also an out-patient service established for and largely operated by students. Each student attends this clinic on one afternoon each week throughout Phase III—that is, for 16 months. During this time he will observe a total of approximately eight to 12 patients. Continuity of contact with the patient helps to teach him the evolution and the natural history of disease and how to assess the problems of treatment.

The Preceptor System.

One of the features of the curriculum is the instruction of students by preceptors. Groups of four or eight students each have a preceptor to help them with their work throughout the four years. The preceptor differs in each of the three phases, and is a tutor and a mentor, a friend and a colleague, and by his service to the student it is hoped to provide the same kind of influence as that derived from the principal in the "apprenticeship" type of medical education of last century.

Other Teaching Activities.

In addition to in-patient clerking and out-patient clinics, the students attend weekly clinico-pathological conferences and regular staff meetings, where the guest speakers are often visitors from other hospitals and medical schools, or from overseas. An important feature in Phase III is the "bioclinical" session, in which groups of students meet weekly for 16 sessions to discuss a given subject with teachers from both basic science and clinical departments. The students contribute from reading the literature, and are encouraged to discuss the subject with special reference to the basic physiological and biochemical mechanisms.

Basic Educational Concepts.

Four important principles underlie the new curriculum.

Self-Education.

It is considered impossible to teach all the facts of medicine in a short space of time. As an alternative, the curriculum aims at developing a critical and permanent interest in the acquisition of knowledge. This is encouraged early in Phase I by instruction in the use of medical literature and in medical statistics, and by the provision of sufficient free time to enable the student to read.

Research Projects.

Special time is set aside for work on a research project in the laboratory, clinic or library. Many students spend a considerable part of their summer vacation working on their project, and research funds are made available to assist the students during this period. Each student must submit a thesis on this work as part of the requirements for graduation.

Free Time.

One and one-half days each week are free for the student in Phase I and Phase II to use as he wishes. During Phase III six months may be spent in any way the student chooses. He may work on the wards or in the laboratory, and he may elect to spend part of this time away from Cleveland, either in the United States or in Europe.

Examination Policy.

Interim examinations are required four times a year in Phases I and II, and a comprehensive examination is given for three days at the end of each academic year. (National Medical Board examinations are also required at the end of the third and fourth academic years.) Many questions are of the multiple-choice type, and the results are graded as satisfactory or unsatisfactory. Only those students who have done unsatisfactory work in the examinations are identified and counselled; the remainder are passed, but no grade is recorded or given. The results of the examinations are used by the faculty as an assessment of the teaching methods and for the identification of students needing help. The project directors, preceptors and instructors make written reports on the ability and work of each individual student.

The Conduct of the Curriculum.

A strictly selected student body and a large, competent and enthusiastic faculty with ample financial support are the firm foundations on which the framework of the programme of medical education is based.

Student Selection.

Western Reserve University School of Medicine accepts approximately 80 new students *per annum*. In 1955 there were some 900 applicants for these 80 places. This ratio of 11·0 applicants per place approaches the figures for other leading American schools, such as Harvard, Columbia and Cornell (Turner *et alii*, 1956). No applicant with less than a B grading from pre-medical college will be considered by the selection committee. All candidates for medical schools take a series of admission tests that are conducted on a national scale. Those meeting these requirements are personally interviewed before final selection.

Faculty Enthusiasm.

The teaching is organized by committees, which decide the scope of the subject matter, arrange classes, lectures and laboratory instruction, and produce an outline of the substance of the lectures and a laboratory manual. The work involved is done willingly and enthusiastically. All members of the faculty are critical of their own work, frequently meeting to discuss the value of the curriculum in terms of student progress. They invite student criticism and indeed this is an outstanding feature of the school.

Financial Support.

The large teaching staff, the construction and equipment of the student laboratories, and the special teaching clinics necessitate large sums of money. This money is obtained entirely from private sources, since Western Reserve University, like other private American universities, receives no financial support from the Government (with the exception of grants for research projects). Grants from the Commonwealth Fund of New York made possible the initiation and some of the maintenance of the current programme. There have also been many other benefactors.

Post-Graduate Education.

The pattern of teaching as described continues after graduation, the years spent as an intern and resident being an extension of undergraduate teaching, with clinical meetings, seminars and clinico-pathological conferences as the main teaching methods. Clinical appointments provide controlled experience under supervision. Specialist training is obtained by a succession of resident appointments, satisfactory fulfilment of which is essential before any graduate can be considered for recognition by specialty examining boards. Many post-graduate students work on research projects in their specialty and at the same time obtain the maximum practical experience in their field.

Discussion.

The advantages of the curriculum are seen particularly in the teaching of the pre-clinical subjects. No longer is the structure of the kidney taught in one year, its function in the next, its diseases in the next, and clinical manifestations in the final year. However, the continued emphasis on the practical significance of basic science teaching was reflected in the students' attitudes to clinical problems in the wards. We were impressed by the detail with which the history, physical signs and laboratory data were recorded, but noted the frequency with which there appeared to be failure to interpret the facts in terms of the probable diagnosis. This apparent defect in clinical acumen and judgement is being accentuated by the tendency to recruit basic science workers to assist in the ward teaching.

The philosophy of clinical teaching is that the student should be "taught in depth"; that is, that the patient's problems must be approached from all possible angles by the student, so that a full social, economic, psychiatric and laboratory examination of every patient is made by each student during his basic clerkship. To achieve this the student has practically no other commitments during his four months of basic clerkship, and the allocation of patients is strictly controlled so that the student is never overworked. During this time the student studies only 20 to 30 patients. Consequently he gets relatively little clinical experience. The limitation of patient load in out-patient teaching clinics, together with the free choice of allocation of six months of his clinical training, varying amounts of which may be in basic science laboratories, indicates why the graduating student may have seen only a few cases (or even none) of common conditions such as pneumonia, varicose veins or hernia. Three factors must be taken into account when this is being considered. First, it is considered a practical impossibility to expose a student to all facets of medicine, surgery, obstetrics, gynæcology and associated specialities in his undergraduate teaching. Therefore the accent of teaching is on principles. Second, it is considered better to study one patient thoroughly than a dozen superficially. Third, the intern year is looked upon as an opportunity to gain clinical experience under the direct supervision of a resident, and this is thought to compensate for the small number of patients seen by the student during his undergraduate training. During the residency the young graduate learns by routine work, but also by cooperating with his chiefs in research projects in his specialty. This is in contrast to post-graduate work in Australia, which is characterized by study for frequent repetitive examinations.

Summary.

The origins and organization of the new teaching programme at Western Reserve University are described.

Special teaching facilities and basic educational concepts are discussed. The student is very well versed in pre-clinical sciences, and is confident and critical, but there is an apparent deficiency in the extent of his clinical teaching.

Acknowledgements.

One of us (I.S.E.) was the Royal Melbourne Hospital Cleveland Fellow, and wishes to thank the institutions concerned for the opportunity to work in Cleveland. We are indebted to Professor T. Hale Ham for providing facilities to observe the teaching methods and for helpful criticism in the preparation of this paper.

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ODD SKIN TUMOURS.[1]

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WITHIN recent years I have cultivated, as a not very serious hobby, an interest in skin tumours, and I must say that I have derived from it quite a lot of fun and even a measure of satisfaction. I seem to remember that my attention to them was stimulated, in the first instance, by such a paucity of clinical material in the teaching field that I felt constrained, for my students' diversion, to exploit to the full every deviation from normal, however insignificant.

Now, it is quite astonishing how common are minor skin tumours, certainly in the adult population. Many of them we wear in obvious places for all the world to see, but many more we hide away where only curious eyes are likely to find them out. To test the truth of this assertion, tonight as you go to take your rest, in the privacy of your own boudoir, please peer Narcisuss-like into the glass and count the blemishes you will find there, and later, as you wallow in comfort in your bath, conduct a secret inquiry into the lesions at other sites.

You may well be surprised at what this careful search will reveal, both in quantity and in variety—innocuous floppy skin tags on short pedicles, harmlessly erupting from the skin of the neck or of the axilla; moles, large and small, prominent and insignificant, smooth or warty, hairy or bald, deeply pigmented or almost amelanotic; angiomata lingering on from childhood and unashamed of their antecedents; tell-tale spiders, equally innocent companions of the telangiectatic pattern on the weather-beaten countenance, or maybe more vicious and giving the lie absolute to even the strongest claims to a life of sobriety.

Some of us, alas, may already carry on our spreading waistline the senile angiomata of Campbell de Morgan. It may be some comfort to recall that in this context senility begins in the forties or thereabouts, and the same is true of the immensely frequent senile warts, which blossom sparingly on the face but often in rich profusion on the trunk.

Senile keratoses in the blue-eyed, fair skinned Nordic stock are almost the rule on the face and hands of the elderly. Even in this city of uncertain sunshine, squamous cell and basal cell carcinomata are, by British standards, two a penny.

These are commonplace things, and the total count from such an audience as this is sure to be considerable. But maybe you will find among them some odd tumours, and I certainly hope you do. For, even at the risk of being charged with soliciting, I would ask you at the exhilarating moment of discovery to bear me in mind, for I am in this respect not unlike an unrepentant stamp collector, and no significant skin lesion can regard itself as safe as long as it remains even beyond the immediate reach of my scalpel.

An awareness of the numbers and varieties of skin tumours prompted me to consult the standard monographs on dermatology, so that, like a botanist wandering through a garden, I could aspire to naming the flowers in my dermal perambulations. But here I found, all too often, that my knowledge was only confounded and all too often confused by a complicated nomenclature with a host of variants, and I have often had the urge since then to re-write these works in simple words for simple surgeons.

I have not, with the passage of time, become a dermatologist, nor can I make claim to have become really competent in the diagnosis of the most ordinary of skin tumours. I have, however, achieved on occasions tremendous, but quite unreasonable, satisfaction from being able to put a name to a skin neoplasm and to plead my case with such conviction with my colleagues that large sums of copper money have subsequently been observed to pass from hand to hand.

Although I know full well that there are in my audience tonight men, and maybe women too, who are much more competent than I to argue the case both clinical and pathological, I have been bold enough to elect to discuss with you a few somewhat unusual skin tumours which are likely from time to time to come within the experience of the practising surgeon. In calling my talk "Odd Skin Tumours" I am using "odd" in its fourth meaning as set out in the "Shorter Oxford Dictionary"—to signify that they "do not belong to any particular set" and are "unconnected"—rather than in the fifth sense, which suggests the extraordinary or the bizarre. You may find, however, that one or two of them seem to deserve the appellation "odd" on both counts.

In June, 1956, an elderly man was admitted to the Royal Melbourne Hospital under the care of Dr. Ian Wood, suffering from profound anæmia, which was attributed to an enormous ulcerating tumour in the right scapular region. It had been observed to grow very slowly over a period of 50 years. It was, at the outset, like a pea under the skin, and 10 years later it was still no larger than a shilling. It was, however, irritated by rough towelling during his athletic activities, and when in the course of his work he humped bags of wheat. After 25 years it had begun to ulcerate and to bleed a little, and both of these processes had gone ahead steadily over the next quarter of a century. At the time of his admission to the Royal Melbourne Hospital, he was found to have a massive and most unsavoury tumour occupying almost the entire scapular area on the right side. Although it was a monstrous tumour, its rate of growth had obviously been slow, for it had taken 50 years to reach its present dimensions, and there was even at this stage no hint of metastases.

A young married woman, aged 33 years, had a tumour under the skin of the abdominal wall, which she believed to be a birthmark. After a miscarriage it grew rapidly in size and eventually ulcerated. Three years later, a minor injury to the tumour started torrential bleeding, and she was for this reason admitted urgently to the Royal Melbourne Hospital under the care of Mr. W. E. A. Hughes-Jones. The original "birthmark" (so-called) appeared to be represented by a diffuse lobulated tumour mass below the right costal margin. Growing on this base and erupting out on to the surface was a large polypoid fungating tumour, with areas of ulceration covered by a foul discharge. The entire mass had, as in the first case, a well-defined border, and once again there was no hint of any metastases.

A biopsy of each tumour was examined, and the second tumour was excised. In each instance a clinical diagnosis of *dermatofibrosarcoma protuberans* was sustained by our pathologist, Dr. J. D. Hicks.

These tumours were first described in 1924 by two Frenchmen, Darier and Ferrand, who called them *"dermatofibromes, progressifs et récidivants"*. It was in the following year (1925) that Hoffmann, writing this time in a German journal, first called them *"Dermatofibrosarkoma protuberans"*, and it is by this name that they are now best known.

The tumour is, of course, a rare one. George Pack, who almost passed this way last year when he addressed the Royal Australasian College of Surgeons' meeting in Dunedin, went through the records of the Memorial Cancer Centre in New York for 20 years with the aid of a young Canadian, and they collected only 39 (Pack and Tabah, 1951).

The experiences of others who have inquired into this problem seem to have been little dissimilar; but I still

[1] Read at a meeting of the Victorian Branch of the British Medical Association on September 4, 1957.

have a "hunch" that the condition is not quite the rarity that the number of published cases would suggest. It is possible that many are indexed under other headings and that not a few pass unrecognized. And yet, we should be able to pick it out, for the clinical story is in a typical case quite striking.

The history is always very long, although the patient often presents himself for treatment in middle age. Sometimes its beginning seems to date from birth or soon after; but more often the tumour presents in early adult life as a little nodule in the deeper part of the skin, which very slowly increases in size over a period of some years. Sometimes there are several such intracutaneous nodules, which coalesce to form a densely hard, fibrous plaque, involving the dermis and the subcutaneous tissue, but not the subjacent muscle or bone.

This is the first phase of development, and it is followed after a period commonly of one to four years, by a second phase of active growth. During this period, which may last only a few weeks or months, there appears on the surface of the plaque a cluster of firm, projecting nodules. By the time the patient comes for treatment, they may measure five to ten centimetres across, and present as a cluster of hemispherical sessile, or occasionally pedunculated, lobulations. The overlying skin is bluish-red or purplish, and as the tumour increases in size, so it may come to ulcerate spontaneously, if it has not already broken down and bled after even a trivial injury.

A youngish man reported to Hammersmith Hospital, London, complaining of pain in the chest, with a cough and loss of energy of 12 months' duration. He was found to have a segmental collapse of the lower lobe of the right lung and a tumour of the related bronchus. On physical examination a second tumour was found on the anterior abdominal wall. It had been slowly increasing in size over a period of 25 years, but its growth had been more rapid during the previous 12 months or so. The pedunculated tumour was set on the summit of an irregular thickening of the skin, measuring about four or five centimetres across. An early diagnosis of neurofibrosarcoma with a pulmonary metastasis was not long sustained, and later operation confirmed that there were two unrelated lesions—namely, a *dermatofibrosarcoma protuberans* and a cancer of the bronchus.

Histologically, this type of tumour is found to have the structure of a rather cellular fibroma, over which the epidermis is stretched and thin and bereft of its hair follicles and sweat glands. The microscopic picture is not nearly so distinctive as is the clinical history.

Although to the naked eye it may seem to be encapsulated, when it is examined under the microscope fine linear projections will be seen extending well beyond what appears to be the tumour margin. No doubt this is the reason for its notorious tendency to recurrence after a too-limited local removal. Although clinically and histologically it often looks aggressive and dangerous, metastatic spread is almost unknown. It is easy enough to be rid of it once and for all if one excises the tumour widely along with the underlying fascia. Often a free graft will be necessary to close the defect that remains.

Now let me turn to a tumour, the pathogenesis of which is, I believe, still somewhat obscure. We call it a "benign calcifying epithelioma", or alternatively, if we are afraid that such a title implies a contradiction in terms, we omit the "benign" and call it simply a calcifying epithelioma. I think, however, that I am right in saying that French pathologists use the term "epithelioma" (and quite correctly too) to apply to any tumour, benign or malignant, which arises from epithelium, and it was a French author who first described this particular tumour in Paris in 1880. He still retains eponymous association with this tumour, and his name is Malherbe. We are told that this too is an uncommon tumour. For example, Lever (1949), on going through 30,000 surgical specimens in the Massachussetts General Hospital, encountered only 15, and Allen (1948), in the files of the United States Army Institute of Pathology, had to go through 8000 to find 38 examples. Dr. J. V. Hurley (1955), working here in Melbourne, was able to trace 25 over a period of 12 years. But most of these tumours go unrecognized, and are excised only to be tossed aside as sebaceous cysts without ever finding their way to the pathologist.

This is a tumour of early life, most of the patients being aged under 20 years or thereabouts. The patient comes complaining of a painless lump on the skin, which has been growing slowly larger for a period of time varying from months to as long as 10 years. The majority of these tumours are found on the face, with the upper extremity as a rather poor second.

The tumour, when first seen, may be no bigger than a hazel nut, and the biggest will seldom be larger than a hen's egg. It is subcutaneous in position and is seldom significantly tethered to the overlying skin, which may become very thin and may sometimes ulcerate. It is strikingly firm or even hard, mobile, sharply defined and non-tender. An X-ray film, if thought of, may show the presence in the tumour of calcifying material.

The tumour is sharply demarcated, lying in the dermis or subcutaneous tissues, and is quite separate from the overlying dermis, which is in all respects normal. There may be a gritty sensation when the tumour is cut with a knife. Histological examination reveals a distinct capsule, and the tumour is made up of epithelium; this is of two types which can be recognized quite clearly under the microscope. First of all there is the so-called "mummified epithelium", which consists of masses of eosinophile material, in which the cell outline can still be recognized. However, the cells are all dead and they are surrounded in most cases by viable cells which are strikingly basophilic. There is a boundary zone of transition between the two. Sometimes there is recognizable squamous epithelium immediately under the capsule. In the mummified epithelium there will be areas of calcification and even of ossification. The tumour shows no connexion at all with the epidermis. In the tissue stroma there is sometimes a foreign body and giant cell reaction; the peripheral viable epithelium may resemble somewhat that seen in a basal cell carcinoma.

It is quite clear, from experience in the management of these tumours, that they are entirely benign. The treatment is the simple one of enucleation; there is no risk of malignant degeneration or of recurrence.

There are conflicting views about the pathogenesis, but the one which seems most attractive is that the tumour arises from hyperplasia of the epithelial lining of an epidermoid cyst, the process of proliferation being followed by subsequent central nerosis and later calcification.

It is not a true neoplasm and is of little consequence—easy to remove and with almost no risk of recurrence. Bear it in mind as a diagnostic curiosity, when you are confronted in a young person with a firm, mobile subcutaneous tumour, which feels like a hard sebaceous cyst, but which is unattached to skin.

And now, let us move on to consider a tumour—and once again it is one of obscure pathogenesis—which has received a great deal of attention within recent years.

MacCormac and Scarff (1936), just over 20 years ago, described (although perhaps not for the first time) 10 examples of a distinctive skin tumour which they called *molluscum sebaceum*. Oddly enough, it was a good many years before this paper attracted any considerable interest, but this omission has been amply made good in more recent times.

Mr. J. T. Hueston (1956), of this city, in an excellent paper on this topic which I can heartily recommend to you, aptly called it "a sheep in wolf's clothing"[1], and for a very good reason.

It is a tumour which both clinically and histologically very closely resembles a squamous cell carcinoma and is often treated as such. This has two unfortunate results. First, the patient may be submitted to quite unnecessarily radical treatment (for, as we shall see presently, the condition is not only benign but self-resolving), and second, the results of treatment of skin cancer may be improved quite unjustifiably by the inclusion of such benign lesions in the final telling.

Molluscum sebaceum is much more common than *dermatofibrosarcoma protuberans* or benign calcifying epithelioma. I see maybe four or five cases a year, although my students suspect that I make this strange diagnosis far too often. In the skin department at St. Thomas's Hospital in London, 29 of these tumours were seen in two years (Rook and Whimster, 1950).

The condition mimics squamous cell carcinoma very closely. Both occur in the elderly, and both occur on the exposed parts—on the face and ears and on the backs of the hands and fingers. For all practical purposes it does not affect mucous membrane.

It is first noticed by the patient as a small nodule, which grows rapidly for a period of six to eight weeks to reach its maximum size—a diameter of 10 to 15 millimetres. This relatively rapid growth is one of its most striking and distinctive clinical features. It has been said that the mature lesion looks not unlike "a half orange resting cut side down on a plate" (Purdy, 1953), and that is not a bad description. As one traces the normal, healthy adjoining skin to the margin of the tumour, quite suddenly it rises up the side of the orange to a height of five millimetres or more. Sometimes the margin of the tumour may actually bulge out beyond its point of attachment. There may be a rim of erythema round its base, but the sides of the tumour are covered with unbroken normal or rather pale epithelium. This gives way as one rises on to the summit to an obvious crater occupied by an irregular brownish plug of keratin; this really represents the top surface of a core which occupies the central part of the tumour. It may be possible to express a bead of pus from the interval between this keratin plug and the wall of the recess in which it is contained.

The tumour is self-resolving, and runs its course in a year or thereabouts. First, there is the period of growth, lasting two or three months. This is succeeded in the untreated cases by a slow separation of the core. The process can be accelerated by enucleating the core with a sharp curette, a manœuvre which in a mature case will cause only the mildest discomfort. The overhanging crater edge of the cavity remaining will now be evident, as will the papillary processes on its floor. If the plug is not removed, it will quite slowly undergo a process of spontaneous extrusion, after which the hole fills up and the tumour flattens, to leave a puckered scar.

The histological picture of the tumour is distinctive enough when it is available for section in its entirety; but a fragment from the summit or even from the base mimics a squamous cell carcinoma almost completely.

The Americans call the tumour a kerato-acanthoma, to indicate the two most evident features of the histology—keratin production and prickle-cell formation. The central part of the tumour has a complex papillary structure, each papilla sprouting keratin. The epidermis as it is followed to the edge of the crater rises up and then bends back sharply to form the lip of the brim, and becomes continuous with the papillary lining.

The histological resemblance to squamous cell carcinoma is, however, very close, and it is no wonder that a dermatological pathologist has suggested for it the name *"molluscum pseudocarcinomatosum"*. The tumour will recur if inadequately removed, and sometimes more than one is present.

We can justify use of the description "tumour" only in its literal sense, meaning a swelling, for there is nothing to suggest that it is neoplastic in nature. The pathogenesis is, in fact, obscure; search for a responsible virus has so far been fruitless. Metastases are unknown.

Since the condition is known to be self-resolving, the method of treatment selected seems to me to be of little consequence, except that the method of choice will be the one which most quickly accelerates cure and with the minimum amount of risk and inconvenience. It is enough to turn out the core, and slicing it off flush with the skin will be equally effective. These methods have, however, the very great disadvantage of not affording adequate material for microscopic confirmation of the diagnosis. The same argument can be advanced about radiotherapy, which has, however, been shown by experience to achieve cure even when used in comparatively low dosage.

It is true that the tumour does sometimes recur at the original site or in the vicinity; but recurrence will always raise doubt in the clinician's mind about the safety and confidence of his clinical diagnosis, and here lies the real problem of *molluscum sebaceum*.

I have already drawn attention to two of its most distinctive clinical features. The first is its rapid growth, measured usually in weeks. A squamous cell carcinoma may take the same number of months to attain a similar size, and the story of a basal cell carcinoma may well be recorded in years. The second distinctive clinical feature is its appearance and the presence of the keratin plug. But even when one's confidence in the diagnosis is based on a considerable experience, mistakes can be made.

> Not long before I left England two patients with *molluscum sebaceum* were referred to me from the skin clinic on a single afternoon. Both seemed to dermatologist and to surgeon alike to be quite classical; but one tumour promptly recurred and grew quickly, and it all too soon became abundantly clear that it was this time a "wolf in sheep's clothing".
>
> Within recent months I demonstrated a tumour as a *molluscum sebaceum* to my group of students at the Alfred Hospital. The lesion was on the back of the hand of a very old man, and it had grown rapidly in a matter of weeks. I went on satisfactorily to dislodge the central core, but was dismayed when it recurred quite quickly. This time the lesion was completely excised and reported to be a squamous cell carcinoma (although it is true that in my arrogance I still am bold and unreasonable enough to question just a very little the exactness of our pathologist's diagnosis).

If the diagnosis, clinical and histological, is so difficult, should we not always play for safety and carry out an excision of the entire tumour and a collar of the surrounding healthy skin? But this would seem to be most undesirable. I believe that one can learn to pick out *molluscum sebaceum* with confidence, and one is likely to be in trouble only when one is in doubt. When one is in doubt, excision would seem to be the safest course.

I hope that I have time to mention one of the most fascinating of all skin tumours—the glomus body tumour or glomangioma. I think that few pathologists would give it a place in a treatise on neoplastic disease; it probably represents a distortion of development or a hamartoma. Someone has tried to call it a glomangiecton. Uncontrolled growth of the tumour and metastases are unknown. The clinical interest and importance of the tumour lie in the very considerable symptoms for which a very small lesion may be responsible.

Glomus bodies are normal anatomical structures of the skin and especially of aeral skin—as, for example, under the nail, on the tips of the fingers and on the palm. Each has a somewhat complicated structure, but consists essentially of a curious arterio-venous communication with a supporting muscle framework and rich nerve supply. These bodies have an important role in regulating the blood supply to the skin of the extremities and also in the control of body temperature.

About 35 years ago Masson, a renowned French pathologist (Masson, 1924), recognized that the glomus was the starting-point of the particular variety of skin tumour which we are now considering, which had been well documented by an Edinburgh physician in the year of Napoleon's retreat from Moscow (Wood, 1812), and which had come, for this reason, to be called the "painful subcutaneous tubercle of Wood".

Quite the most striking clinical feature is pain. Although to begin with it may be mild and not severely incapacitating, as time goes on it increases in intensity to such a pitch that patients may come asking for amputation to obtain relief. Injury seems occasionally to bring on this symptom for the first time; but it is often exceedingly difficult to decide how significant a determining factor it has been. It tends to recur in severe paroxysms, which may come spontaneously by day or by night. Much more

often they are precipitated by pressure, or by changes in environmental temperature—upwards or downwards. Even the pressure of clothing or of bedclothes may be intolerable, and patients will go to great lengths to protect the tender area, for very often there is a trigger point, which need only be touched to set off a paroxysm. Change in position of the limb (especially dependency) may also bring on an attack, and a relationship to menstruation has occasionally been noted. The pain often radiates widely, both proximally and distally, and its distribution is often a poor guide to the site of the tumour.

Characteristically the symptoms are striking and the signs minimal. Very occasionally a tumour is first noticed by the patient and is removed while it is still painless. Not infrequently the patient comes complaining of agonizing pain in a limb for which there is no obvious cause. The tumour may be first detected many years later. Careful searching with a pin may, in such a case, reveal a point of exquisite tenderness, marking the position of the tumour. Very often, however, the patient has found for himself a painful nodule in the skin. It presents as a firm, rounded tumour in the skin measuring only a few millimetres across (with 10 millimetres as the upper limit). It is situated in the dermis and may cause an appreciable projection on the surface. Its colour is related to its depth, the more superficial tumours having a reddish purplish tint and, in contrast, those more deeply placed being blue. The elusive subungual lesion, for example, shows only as a blue discoloration.

A paroxysm of pain may be induced by pressure over the tumour or occasionally by inflating a tourniquet cuff at a point proximal on a limb to a level above the venous pressure, or simply by inducing dependency congestion; plunging the limb into a basin of hot or cold water may also precipitate an attack.

Occasionally changes in the local blood supply are noticed by the patient, especially during a paroxysm. Engorgement of the vessels in the vicinity is noted most often, with a resulting rise in skin temperature; but a fall in local skin temperature has also been reported. Coincidental sweating in the affected limb has also been described.

Cases have been reported in which a large glomus in the finger pulp has led to a clean-cut cortical erosion of phalanx. Many multiple glomus tumours have been reported, Eyster and Montgomery (1950) finding 90 in one patient. It is interesting that only two of them were painful.

When a patient comes complaining of excruciating pain for which there is no discoverable cause, it is not surprising that he is often diagnosed as "neurotic". The diagnosis is, in such cases, often for long overlooked. Pain of wide distribution may also be misleading as instanced in the classical report by Blumenthal (1937), in which pain in the precordial area and left arm was for 16 years attributed to angina before it was ultimately cured by the removal of a digital glomus tumour.

When a patient (and especially a female) relates paroxysmal pain to a nail bed, it is safe to make a diagnosis of a subungual glomus tumour, even if there is no detectable abnormality in this situation.

Of the other painful skin lesions, leiomyoma is the most common, and in most cases the differentiation between the two can be made only after histological examination.

Surgical excision will give prompt and lasting cure. Murray and Stout (1942) reported an infiltrating tumour which recurred, but this is a rare exception. The tumour, as seen at operation, is bluish and well circumscribed, and is situated in the dermis but growing down into the subcutaneous fat. It is best exposed under general anæsthesia; the use of local anæsthesia may completely obscure a small lesion. The use of a tourniquet may sometimes help in identification of the tumour; sometimes, however, it is a hindrance, by blanching it completely. Rowntree advised searching carefully under the deep fascia after removal of a single tumour, in case a second or third was being overlooked.

The tumour should not be simply shelled out, but removed with an ellipse of the covering skin. For a subungual lesion the nail must first be removed, and it may be then that the tumour is for the first time recognized. If the bone is involved, it is probably safer to remove the phalanx, at least in part.

Conclusion.

The catalogue of odd skin tumours could be a very long one—*mycosis fungoides*, the turban tumour, Cock's peculiar tumour, the sebaceous adenoma, the sweat gland tumours and a host of others. I must, however, rest content with the few I have selected.

You may complain that they are uncommon and, for this reason alone, scarcely worthy of much attention. Further, they are for the most part benign and merit local excision: surely it is, under such circumstances, soon enough to know the diagnosis when the report comes from the pathologist?

Aware of these arguments, I have none the less applied myself to my task in the firm belief that your interest in things medical is not wholly utilitarian, and that you will always derive immense pleasure and satisfaction from being aware of the truth. There are, it is true, some who under such circumstances consider time ill spent in such pursuits. May they not allow such sentiments to colour their reactions to studies in other and more general fields!

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Reports of Cases.

UTERINE INVERSION.

By David Howell,
Sydney.

This case is being reported because of the rarity of the condition. Indeed, if present theories as to the aetiology of uterine inversion are correct, then such cases should become even rarer. This also affords an opportunity to resurrect the Haultain operation, details of which lie buried in the obscurity of older text-books.

Clinical Record.

Mrs. A.'s admission to the Royal Hospital for Women, 18 days after her confinement, was arranged by her local

practitioner, who gave the following information in his accompanying letter:

> Mrs. A. is aged 26 years. She had a primary uterine inertia and a female baby was delivered by forceps on September 22, 1953. After waiting an hour the placenta had not come away so she was anæsthetized a second time and a manual removal performed. Then it was noticed that the uterus was inverted. It was immediately replaced and the patient was transfused. Her blood group is O4, Rhesus positive.
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> She went home five days ago (October 10) and to-day she noticed a mass between her labia. On examination this was seen to be her uterus.

These salient features were confirmed by the patient, who stated that since her confinement she had noticed a constant blood-stained discharge. She had been kept in bed for 10 days after delivery, and during that time she had two bouts of heavy dull lower abdominal pain associated with severe hæmorrhage. When allowed out of bed she had felt weak, and her third episode of pain with heavy bleeding had occurred whilst she was on the toilet. During the five days she had been at home the blood-stained discharge had diminished slightly. The discharge had been offensive on occasions, but there were no symptoms of urinary or pelvic infection. This was her first pregnancy, and the ante-natal period had been uneventful, labour commencing one week before the due date. There was no relevant past history.

On initial examination, Mrs. A. had a pulse rate of 90 per minute, a blood pressure of 110/75 millimetres of mercury and a temperature of 99·4° F. There was no abdominal tenderness, and vaginal and bimanual examination showed that she did in fact have a uterine inversion; but it was impossible to feel beyond the bulky corpus to be sure whether it was a second or third degree inversion. Her hæmoglobin value was 9·2 grammes *per centum* and the white cell count 12,500 per cubic millimetre, 70% being neutrophils. The urine was normal on microscopic examination, and sterile. From the vaginal smear were grown a few colonies of *Staphylococcus albus*, and a moderate number of *Bacterium coli* organisms which were sensitive to all antibiotics except penicillin.

The patient was confined to bed and treatment was begun with streptomycin given by intramuscular injection, the transfusion of two pints of compatible blood and warm saline douches administered with low pressure. In three days her temperature fell to normal and the vaginal discharge was no longer offensive. The honorary obstetrician in charge recommended examination of the patient under anæsthesia, and if digital replacement was not possible, as would probably be the case, he advised an abdominal approach and division of the posterior rim of the inversion.

Accordingly vaginal examination was carried out under "Pentothal" anæsthesia on October 20, 28 days after the patient's confinement. By firmly retracting the perineum and lateral vaginal walls the narrow rim of the cervix was visible anteriorly. The cervix was felt as a firm but not tight ring, and about three quarters of an inch of its canal remained non-inverted. The inverted corpus was four inches long and incompressible. There was slight up-and-down piston type movement at the neck of the inversion, but the greater relative size of the corpus prevented reduction.

The lubricant (warm sterile glycerin) was douched out of the vagina, the anæsthetic was extended with curare, and the pelvis was exposed through a subumbilical mid-line incision. The findings were the classical ones of a marked second degree inversion, with the attenuated round ligaments and Fallopian tubes passing down through the constriction. The ovaries were balanced on the rim. The constricting rim was pliable but not really dilatable, so that stretching in one diameter led only to diminution of the diameter at right angles. Also, when the edge was grasped by a pair of Allis forceps the soft uterus tore very easily.

The posterior rim was therefore incised in the mid-line until the uterine cavity was exposed. Two fingers were inserted under the fundus and it was slowly pushed upwards. The initial reduction occurred easily at the neck of the inversion; but as the fundus approached, the uterine wall began to tear like wet blotting-paper upwards in the line of the original incision. Nothing could be done to limit the length of the tear, partly because of the softness and lack of resiliency of the myometrium and partly because of the bulk of the fundus. This latter was due to œdematous thickening and to adhesions between the inverted sides, which were torn apart as the final "dimple" was being removed. There was surprisingly little bleeding from the uterine wound, which was about three inches long and extended from one inch above the cervix almost to the fundus. It was repaired in two layers with interrupted and continuous plain gut sutures. The weakened area at the fundus was plicated. The uterus remained anteverted, very pale and with a soft pliable consistency.

The post-operative course was uneventful apart from a rise in temperature to 101° F. for the first 36 hours, and a slight brown vaginal discharge for five days. The patient was discharged from hospital, and to date there has been no recurrence.

Discussion.

The frequency of this complication can be quoted, depending upon the authority, at from one in 8500 to one in 400,000 births. The fact remains that it is a rare complication, adequately reviewed by Das (1940), the world figures having been recently brought up to date by Bell *et alii* (1953).

In retrospect, it is impossible to decide whether this was a true puerperal recurrence or whether the uterus had not been completely replaced on the first occasion. Nevertheless the patient's local practitioner deserves great credit for his rapid and efficient treatment of this dangerous condition. Technically the Haultain method is so simple and straightforward that one would recommend it as a standard procedure for the type of case described above, in which the uterus is to be conserved. By comparison alternative methods seem hazardous. Aveling's repositor (even if one was available in any modern obstetrical unit) would need to have the cup specially made to the size and shape of the inverted mass, and in view of the possibility of adhesions between the two inner surfaces it is doubtful whether the repositor would completely succeed. The same argument would apply to vaginal incision of the constriction ring either anteriorly (Spinelli) or posteriorly (Kustner). In addition, these two operations could be technically difficult if the inversion was bulky. Huntingdon's operation, however well it may succeed in the recent acute inversion, was impossible here and would have led only to hysterectomy by *morcellement*. Abdominal division of the constriction ring anteriorly would be risking trouble unnecessarily, because the bladder wall was just beginning to be dragged into the depths of the inversion.

The only weakness of the operation is the lingering doubt that the uterine wound may not heal adequately in view of the peculiar consistency and relative avascularity of the myometrium. (It is interesting to note that Haultain in his original case met "troublesome bleeding from the stitch holes".) In this event, with the deficiency in the posterior wall, uterine rupture may come in a more silent and sinister clinical form than one would expect. Uterine rupture following Haultain's operation has not yet been recorded in the literature, although Carlisle (1955) recently reported a case of rupture following manual replacement of an acutely inverted uterus.

Acknowledgements.

I desire to express thanks to Dr. Lois Benson, Honorary Assistant Obstetrician and Gynæcologist, Royal Hospital for Women, for permission to report this case.

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Reviews.

The Doctor's Signature. By Hamilton Johnston; 1957. London: Victor Gollancz, Limited. 7¾" x 4¾", pp. 258. Price: 13s. 6d. (English).

THIS is a cheerfully sordid book, carefully compounded to a formula likely to have a popular appeal. The doctor's private life is always a good foundation, especially when retailed as to the professional side, with the air of one who appears to know it from first hand. In this instance, the setting is an English industrial town in the Welfare State. Serve with a sauce of light-hearted cynicism, sprinkle liberally with sex, add an inevitably fatal illness for drama, a wealthy industrial magnate for atmosphere, and a couple of simmering blondes in the wings—one top drawer, one bottom drawer—and the publishers may reasonably anticipate a modest success.

Histological Technique: For Normal and Pathological Tissues and the Identification of Parasites. By H. M. Carleton, with the collaboration of R. A. B. Drury; Third Edition; 1957. London, New York and Toronto: Oxford University Press. 8½" x 5½", pp. 367, with illustrations. Price: 49s. 9d.

FIRST published in 1926, this book has grown with the years and experience of its author into a monument to his technical skill. He had just completed its revision when he died in 1956, and in a foreword Professor G. R. Cameron, of University College Medical School, London, pays tribute to this "incomparable histologist who preserved the traditions of the great pioneers of the nineteenth century in a rapidly changing world. A pupil of Gustav Mann, whom he succeeded at Oxford, and of Champy, he inherited their common sense and uncanny intuition, and welded these qualities with his innate artistry and broad outlook into something that was unique, and inspiring. His unrivalled practical knowledge of technique was freely drawn upon by J. S. Haldane, Sherington, Florey and others". The art of the photographer has caught these qualities in the new frontispiece, which shows Carleton looking up from his microscope with a cheerful, half-rueful grin, as though to welcome, in spite of himself, the next interruptor of a very busy man. His wisdom is evident in this book, with its clear, straightforward style and detailed directions for the avoidance of "small hidden difficulties". His plan, as outlined in the introduction, was first to describe in detail the fundamental processes of fixation, embedding, section-cutting and staining. No automatic devices are mentioned; either they did not come the way of this master craftsman, or else he disliked them. His second aim was to provide accessory and special methods, adapting the length of the description to the importance of the subject. Thirdly, he has given directions for identifying morbid changes or parasites in tissues. A short list of references to standard works, which in turn provide full bibliographies, is appended.

Eden and Holland's Manual of Obstetrics. By Alan Brews, M.D., M.S. (Lond.), M.R.C.P. (Lond.), F.R.C.S. (Eng.), F.R.C.O.G.; Eleventh Edition; 1957. London: J. and A. Churchill, Limited. 8½" x 5½", pp. 764, with 432 illustrations. Price: 63s. (English).

THE eleventh edition of this well-known British text-book of obstetrics follows the edition of 1953 with a similar format, no increase in size, revised text and additional illustrations and X-ray reproductions. The added X-ray plates in the sections on contracted pelvis and placentography are of particular merit.

The importance of team work in modern medicine is evident in this manual, in which the author enlists the aid of specialists in sections ranging from pædiatrics, radiology, anæsthesia, physical medicine and anatomy to hospital ancillary work, such as that of dietitians, physiotherapists and almoners. The roles of diet and physiotherapy during the ante-natal period are mentioned, and specific instructions according to the London Hospital routine are given in appendices at the end of the book.

The subject of extrauterine gestation would appear to occupy more space than expected in a manual such as this (10 pages of text, 11 illustrations and three X-ray plates). Palmer's sign in the clinical diagnosis of early pregnancy is described and illustrated. Apart from preventive measures, there are no outstanding advances in the treatment of pre-eclamptic toxæmia or eclampsia. Hypotensive drug therapy in pregnancy toxæmia is briefly discussed, with reference to veratrum alkaloids and hydralazine ("Apresoline"). It is noted that the widely accepted Lovset technique for delivering extended arms in abnormal breech delivery is not detailed by the author. The importance of having the forceps ready for the after-coming head in every breech delivery is emphasized. Credé's expression of the adherent placenta in the presence of post-partum hæmorrhage is condoned if performed correctly. The practice of giving ergometrine intravenously before the placenta is delivered is mentioned as a prophylactic measure in post-partum hæmorrhage. It would appear that an intravenous injection of ergometrine or an intramuscular injection of "Pitocin" with the delivery of the anterior shoulder is not routine procedure in the author's practice. The rare but important type of post-partum hæmorrhage due to faulty blood-clotting mechanism (afibrinogenæmia) receives only a line or two in the text.

A helpful section of the book is devoted to "Unexpected Death (or Near Death) in the Puerperium", in which are discussed hæmorrhage and shock, anæsthetic mishap, acute renal failure, puerperal eclampsia, puerperal sepsis, embolism and associated illness. Reference is made to the work of Sheehan and Moore (1953) on renal pathology underlying puerperal anuria and the importance of treatment by maintaining biochemical balance of fluids and electrolytes.

In the treatment of *asphyxia neonatorum*, the use of nalorphine hydrobromide ("Lethidrone") as an antidote against depressants such as morphine or pethidine is mentioned, and the advantages of "mouth-to-mouth breathing" and resuscitation by intragastric administration of oxygen are discussed.

This manual maintains its high standard as a reliable text-book for the medical student, a helpful book of reference for the busy practitioner, and a comprehensive survey for the post-graduate taking higher degrees.

Books Received.

[The mention of a book in this column does not imply that no review will appear in a subsequent issue.]

"The Effect of Long Term Treatment with Dicoumarol in Myocardial Infarction: A Controlled Clinical Study", by Christopher Juel Bjerkelund; *Acta Medica Scandinavica*, Supplementum 330, accompanies Volume 158; 1957. Oslo: Published for the Norwegian Research Council for Science and the Humanities. 9¾" x 6¾", pp. 212; no illustrations.

A report of studies carried out at the Ullevål Hospital in Norway in the period 1950-1956.

"Recent Trends in Chronic Bronchitis", edited by Neville C. Oswald; 1958. London: Lloyd-Luke (Medical Books), Limited. 8½" x 5½", pp. 106, with 72 illustrations. Price: 30s. (English).

This book brings together recent views on chronic bronchitis with accounts of original work by seven contributors.

"Bone Diseases in Medical Practice", by I. Snapper, M.D.; 1957. New York and London: Grune and Stratton. 10½" x 7", pp. 288, with 48 plates. Price: $15.00.

The author has aimed "to present the subject in such a way that it can be used in the daily practice of medicine".

"Surgery of Head and Neck Tumors", by Hayes Martin, M.D.; 1957. New York: Paul B. Hoeber. 10½" x 7½", pp. 448, with 599 illustrations. Price: $18.50.

The author has "attempted to include a comprehensive description of operations for all anatomic varieties of tumors of the head and neck with the exception of brain tumors".

"The Year Book of General Surgery (1957-1958 Year Book Series)", edited by Michael E. De Bakey, B.S., M.D., M.S., with a section on "Anesthesia" edited by Stuart C. Cullen, M.D.; 1957. Chicago: The Year Book Publishers Incorporated. 7½" x 5½", pp. 560, with 128 illustrations. Price: $7.50.

One of the Practical Medicine Series of Year Books.

"The Year Book of Obstetrics and Gynecology (1957-1958 Year Book Series)", edited by J. P. Greenhill, B.S., M.D., F.A.C.S., F.I.C.S. (Honorary); 1957. Chicago: The Year Book Publishers, Incorporated. 7½" x 5½", pp. 600, with 33 illustrations. Price: $7.50.

One of the Practical Medicine Series of Year Books.

The Medical Journal of Australia

SATURDAY, MARCH 1, 1958.

MEDICAL EDUCATION AND THE BRITISH MEDICAL ASSOCIATION.

THE decision of the New South Wales Branch of the British Medical Association to take an active interest in medical education is of far-reaching importance. Action along these lines was initiated on February 12 at a well-attended extraordinary general meeting of the Branch held at the request of the required number of members in accordance with the rules of the Branch. The meeting resolved that a special committee should be set up immediately to consider medical education in New South Wales, with particular reference to the Murray Report. The following composition of the committee was adopted: One member nominated by the active teaching staff of each of the four teaching hospitals in Sydney; three representatives nominated by the Council of the New South Wales Branch of the British Medical Association; one representative of the active teaching staff of each of the three special teaching hospitals (Royal Alexandra Hospital for Children, the Women's Hospital, Crown Street, and the Royal Hospital for Women, Paddington); one representative each of The Royal Australasian College of Physicians, the Royal Australasian College of Surgeons, the Royal College of Obstetricians and Gynæcologists and the College of General Practitioners; one representative of the Senate of the University of Sydney and four representatives of the teaching staff of the Faculty of Medicine of that university; one representative of the Post-Graduate Committee in Medicine in the University of Sydney; one representative of the University of Technology. The committee was also given power to coopt. The final resolution was that the committee should make its report as soon as possible to the Council of the New South Wales Branch and that the Council should take such action as it deemed necessary.

It is sincerely to be hoped that the various bodies invited to send representatives to this committee will do so. There may be difficulties in certain cases, and it is a pity that the alternative was not offered of sending an observer, who could keep the committee accurately advised without implicating the body concerned. Perhaps this can still be done if necessary. It is vital, however, that the nature of the committee should be quite clear. It is not a rival committee to any other. It cannot pretend to any right to "tell the Government what to do". It is simply a committee of the New South Wales Branch of the British Medical Association. That is to say, its task will be to recommend a policy for adoption by the body which represents practically all members of the medical profession in New South Wales. Its composition deliberately allows for the inclusion of those who understand the academic points of view in relation to both medical and non-medical aspects of undergraduate training and those from a wider field who are concerned with fostering the concept that "the doctor is always a student". The immediate task of the committee, to which it will need to bend all its energies, is the consideration of undergraduate medical education; then it can move on to its wider responsibilities. While the urgency of the matter cannot be questioned, it would be unrealistic to imagine that it could furnish an adequate report in a short time, even on the burning topic of undergraduate medical education. It would be quite wrong to submit hasty and ill-considered recommendations in a frantic effort to influence the State Government at all costs before it acts in the matter. A Branch policy that is not carefully considered and based on the best available opinion will not be worth having at all. It will take time to determine such a policy.

Meantime, the advisory committee set up by the State Government continues its deliberations according to its extraordinarily wide terms of reference, which include the order and nature of measures essential to the establishment of the proposed medical school at the N.S.W. University of Technology, the composition of the proposed medical curriculum at the undergraduate, honours and post-graduate levels, any other matters relating to the standard of medical education in New South Wales which arise from the above, and the financing of teaching hospitals. With these important matters under consideration, the remarks already made about the British Medical Association committee must surely apply also to the Government committee. Evidence must be gathered widely from those with first-hand knowledge of these matters and then given the most careful consideration. This cannot but take time, and we earnestly hope that the Government committee is not required to and will not make hasty recommendations. If it does do so, and if the Government indicates that it intends to implement those recommendations, it is to be hoped that the British Medical Association committee will continue to look at the long-term picture. No one doubts that the expansion of this country is only just starting. Any steps taken in the immediate future bearing on undergraduate medical education need not be accepted as determining the pattern of the future. If the British Medical Association special committee and the Branch Council will act with all reasonable speed and yet refuse to allow themselves to be panicked, they will have the chance to do a lasting service to the people of New South Wales in relation to the standard of medical practice in the future.

In the wider field, it is to be hoped that the Branches of the Association in the other States of Australia will do something about formulating a firm policy on medical education. If this is done, the Federal Council, which

found itself unable to act when the question was raised some years ago, may at least be able to act as a coordinator and so to exercise a healthy influence in this important matter as our country grows.

Current Comment.

SPORTS MEDICINE.

THE Executive Board of the World Health Organization has requested the Director-General to study the possibility of including sports medicine in the WHO programme and to submit a preliminary report to the Eleventh World Health Assembly meeting in Minneapolis (U.S.A.) in May. This decision followed a joint proposal made to the Board by Denmark, Finland, Norway and Sweden. The document submitted by the four countries points out that traditional ways of life are undergoing rapid changes as a result of industrialization and automation. The amount of physical work involved in every human occupation has sharply declined, while certain diseases have increased. Coronary heart diseases, for instance, have been shown to be some of the most common causes of death among people whose occupation requires the least amount of physical work. Consequently, physical exercise seems to have become an important public health factor, and one worth careful study. At the same time, the document states, sports are everywhere increasingly practised, as they satisfy man's apparently instinctive urge for motion. They in turn raise a number of medical problems, e.g., the effects of different sports on health and longevity, the prevention and treatment of accidents, mental health aspects of sports etc. Sports medicine is developing into a generally accepted speciality, and, according to this document, several research institutes are studying this new field of medicine in Australia, Czechoslovakia, Germany, Italy, the Scandinavian countries, the Soviet Union, the United Kingdom, the U.S.A., Yugoslavia and other countries. The proposal urges that WHO should take the lead in the field of sports medicine, which offers a new approach for the promotion of public health.

PLAGUE.

FROM early in man's history plague has been the scourge of countries and of continents. H. H. Scott[1] has found references to its as far back as Homer. The best known outbreak was the Black Death which ravaged Europe in the fourteenth century. It is said that in the city of London alone 100,000 perished at this time, and Scott quotes a statement, of which there is, as one might expect, no proof, that altogether in the Black Death 25,000,000 perished. Subsequently many severe outbreaks are recorded, including the Plague of London in 1665. However, in the seventeenth and eighteenth centuries, for reasons that are not entirely clear, plague faded away in Europe and ceased to be a major problem there. Elsewhere, especially in Asia, it has continued: in China and Manchuria major epidemics with many deaths have occurred in the past half-century; in India it is estimated that 11,000,000 died from plague in the first quarter of the present century, but the average yearly deaths had fallen to 50,000 in the period from 1931 to 1935. In Australia plague has never been a major problem, but Scott records several outbreaks. He states that at the beginning of this century plague appeared in Adelaide and Melbourne, but was worst in Sydney, where there were 300 cases and 100 deaths. In 1903 it was again introduced, but no epidemic followed. Twenty years later a localized epidemic followed the arrival of a vessel from Queensland with dead rats on board; in the ensuing nine months 35 cases of human plague occurred in 10 localities around Sydney, but Scott makes no mention of any focus in Queensland.

The latest reports suggest that plague is on the way out. Figures published in the *Weekly Epidemiological Record of the World Health Organization* on January 24, 1958, show that only 514 cases of plague were recorded in 1957 throughout the world. This is accounted for by an unusually low incidence in India. The downward trend of plague in recent years is shown by the following world totals of officially notified cases in successive years (the total for India is shown in parentheses): 1951, 15,399 (8230); 1952, 11,932 (7632); 1953, 7328 (6069); 1954, 1921 (1031); 1955, 1228 (542); 1956, 670 (262); 1957, 514 (44).

An analysis of the cases of plague reported in 1957 throughout the world shows that in continental Africa the highest number were in the north-eastern part of the Belgian Congo, with sporadic cases in Kenya, Tanganyika and South Africa. In Madagascar only 13 cases were reported in the former epidemic area of the central plateau, but 41 cases were reported in the Diego Suarez area. In America active foci were still located in Ecuador, Peru and Brazil; one case was reported in the United States in Texas. On the continent of Asia (outside of China and the U.S.S.R.), of a total of 248 cases, 198 were reported in Burma, 44 in India and four in Vietnam. In Indonesia only 15 cases were officially notified in Java, as against 113 in 1956 and 354 in 1955. During the year the presence of rodent plague was notified in the Belgian Congo and in Hawaii.

[1] "A History of Tropical Medicine", Arnold, London, 1939, 2: 702.

PHYSICAL WORKING CAPACITY IN CONSCRIPTS DURING MILITARY SERVICE.

THE question of physical working capacity in conscripts during military service has been the subject of an inquiry by Dr. Klas Linroth,[1] of Stockholm. He points out that inquiries have usually been directed towards excluding the unfit rather than towards improving methods of grading the fit or determining how to make the best use of the abilities of recruits or soldiers. Some of his findings will not surprise experienced military surgeons. For example, although there was an attempt in some heavy engineering units to obtain conscripts with high working capacity, Linroth notes that at least a fifth of the members of such a unit had a low working capacity. Again, of the members of a group judged by a military board to have poor physique, almost a quarter had been drafted into heavy occupations. Rather more surprising was the overall decline in working capacity during the year's military service. This decline was especially marked in those recruits who had a high working capacity initially. Linroth believes that this is due to a drafting into the same unit of troops of very different working capacities, so that the activities of the unit are largely determined by the needs or abilities of the less capable.

Linroth considers that laboratory methods gave a better assessment of working capacity than the usual military appraisal. He notes some indirect points in his own assessment. Those actively engaged in athletics in civil life or in heavy civilian work tended to have a high working capacity. High body weight, large chest circumference and muscular build were usually good signs, although recruits with weights over 80 kilograms varied considerably in performance. Weights below 60 kilograms were usually associated with low working capacity. Other useful favourable indirect signs were a high blood hæmoglobin value, a high vital capacity and a large heart volume.

Direct tests favoured by the Swedish army authorities were the usual physical examination and a standard stepping test with measurement of the increase in the pulse rate, but Linroth thinks that this test gave rather poor results. He prefers a bicycle ergometer, which has the additional advantage of allowing supplementary tests,

[1] *Acta med. scandinav.*, Volume 157, Supplementum 324.

such as electrocardiography, to be carried out at the same time. Linroth gives numerous tables and graphs establishing normal standards for height, weight, chest measurement, vital capacity, resting pulse rate and standing pulse rate. He also summarizes the results of his physical examinations. In all, his work should be of interest to those engaged in military medicine or in the care of young adults, such as university students or industrial workers.

CHEMOTHERAPY OF TUBERCULOSIS.

ESTABLISHED regimens employing two or all of the three major antituberculosis drugs are not only highly effective but in general safe from the point of view of preventing the emergence of resistant strains of bacteria. There are, of course, problem cases and particular circumstances when some modifications are required or when some drug other than streptomycin, *p*-aminosalicylic acid or isoniazid is required, but these cases are likely to be encountered by the chest physician rather than the general practitioner. Especially with the increasing use of long-term chemotherapy in less severe forms of the disease, the disadvantages of the usual two-drug regimens (the need for injections with streptomycin and the gastro-intestinal disturbances often produced by full doses of PAS are the common ones) have been thrown into relief as it were.

In the earnest search for a "convenient" and effective drug, two, "Nupasal-213" or "Salizid" (*o*-hydroxybenzal isonicotinyl hydrazone) and "Dipasic" (isonicotinic acid hydrazide-*p*-aminosalicylate), appear to have become quite widely used, at least in England. Both have been used alone, and some early reports were perhaps over-enthusiastic. Three reports, by G. W. Allan and others,[1] J. M. Dunbar and R. T. Ritchie,[2] and W. C. Walker and others,[3] which may be accepted as authoritative and reliable, now refute the earlier claims and demonstrate in effect that treatment with either is approximately equivalent to treatment with isoniazid alone. There is thus a great risk of producing isoniazid-resistant organisms if either is used alone, and there is nothing to be gained by using either, in preference to isoniazid, in association with PAS or streptomycin.

In its editorial columns, *The Lancet*, drawing attention to these papers, refers to the heavy responsibilities of drug firms in putting new drugs on the market when already available therapy is known to be so satisfactory. At the same time, the difficulties of assessing new drugs quickly are great; the action of the British Tuberculosis Association in setting up a clinical trials organization, to act in conjunction with manufacturers, is to be commended. Happenings such as those described are best avoided.

A GUIDE TO SOCIAL SERVICE AGENCIES.

THE attention of medical practitioners in New South Wales is drawn to the issue of a new edition of the "Directory of Social Service Agencies", published by the Council of Social Service of New South Wales. It is a valuable guide to the many agencies in the community concerned with every aspect of social welfare. The purpose of the directory, as stated in the foreword, is "to promote efficiency in the field of social welfare by providing a comprehensive, accurate and well-classified account of statutory and voluntary services for the use of members of the Council, members of Parliament and the staffs of government departments, ministers of religion, members of the professions of medicine, law and social work, personnel officers in industry, voluntary social workers and other interested people". Medical practitioners will find information about agencies of interest to them throughout the volume, which is divided into sections dealing with government departments and agencies, health, child and youth welfare, family and adult welfare, service and ex-service personnel and their dependants, seamen, delinquency, immigration, recreational and cultural agencies, and miscellaneous. The section headed "Health" lists and describes a large number of agencies of all kinds under the heading "General" and then provides details of home nursing services, public hospitals and country base hospitals, special hospitals (including those for chronic and incurable diseases, mental health and tuberculosis), the care of mother and baby, care of the handicapped, convalescent and holiday homes for adults, and convalescent homes for children. Medical practitioners who are not already acquainted with this publication will be agreeably surprised at the comprehensive nature of the information that it contains and will find it in constant use. Copies are available from the office of the Council of Social Service of New South Wales at Endeavour House, 33 Macquarie Place, Sydney. The price is £2 2s., but the information provided by the book makes it good value.

HYPERTENSION.

ONE of the more recent drugs for the treatment of hypertension is mecamylamine. Initial investigations in England indicated that this preparation had an effect in lowering blood-pressure, but that it had several troublesome side effects, as they are called. Weakness, severe constipation, xerostomia, impotence, drowsiness and blurring of vision were the most frequent complaints. Now, J. Moyer, C. Heider and E. Dennis[1] have recorded the results of its use in the treatment of 75 patients. Moyer and his colleagues regard a sustained blood pressure above 150/100 millimetres of mercury as hypertension. The dose of mecamylamine was 2·5 milligrammes given twice daily, increasing to 34 milligrammes daily, or more. The average dose given to patients who responded to the drug by a fall of 20 millimetres of mercury or more in the mean blood pressure was 34 milligrammes. Some did not respond to twice this dose. As a result, a number of patients were given 0·25 milligramme of reserpine four times daily, together with mecamylamine, with a more satisfactory effect in reducing the blood pressure. Some patients receiving 5·0 milligrammes of mecamylamine twice daily suffered from marked orthostatic hypertension and numerous side reactions. It appears that constipation may lead to fatal ileus if not vigorously treated with cathartics, "Prostigmin" or pilocarpine. Nasal congestion, weakness, blurred vision, dry mouth, drowsiness, giddiness, impotence and bradycardia are mentioned as occurring in from 30% to 50% of patients treated. Moyer, Heider and Dennis treated their patients for a year or more. They consider that mecamylamine and reserpine are an effective combination, more effective and satisfactory than other hypotensive drugs. They stress the importance of small doses to begin with.

This interesting study shows that some physicians have not yet realized the drastic toxic effects of the treatment of hypertension, or appreciated the necessity of avoiding unpleasant side effects. Satisfactory results can be obtained in the treatment of hypertension by using one or more drugs in combination, in doses very much smaller than those prescribed in this study. Large doses of hypotensive drugs are harmful, distressing and unnecessary. It is not good treatment to cause patients to faint, to die of ileus, or to become impotent, drowsy, weak or defective in vision. With small doses, equally good results can be obtained. It may be, as Moyer, Heider and Dennis state, that mecamylamine and reserpine are the most valuable combination for treating hypertension. It may equally well be that one-quarter of the doses of these drugs used by them, or less, would be just as effective, and much less toxic.

[1] *Lancet*, 1957, 2: 609.
[2] *Lancet*, 1957, 2: 612.
[3] *Tubercle*, 1957, 38: 238.

[1] *J.A.M.A.*, 1957 (August 24).

Abstracts from Medical Literature.

RADIOLOGY.

Regional or Reflex Ileus in Acute Abdominal Disease.

B. R. Young (*Am. J. Roentgenol.*, October, 1957) states that regional or reflex ileus is frequently demonstrated in the neighbourhood of an acute inflammatory process in the abdomen by survey X-ray examination, and therefore it is a valuable indicator of nearby disease. The location of the ileus suggests the site of involvement; in the right upper quadrant the presence of gas-distended bowel often aids in the diagnosis and visualization of an acutely enlarged gall-bladder. Fixation of one or two distended loops is additional indirect evidence of neighbouring inflammatory disease. It is determined by noting the absence of appreciable movement on radiographs taken in the supine, prone and lateral decubitus positions. These views are fundamental requirements and should be supplemented by additional ones when indicated. The author illustrates and discusses the significance of reflex ileus in the diagnosis of acute cholecystitis, perforated ulcer, pancreatitis and appendiceal abscess, and of some other plain film manifestations of these diseases

Neuroblastoma.

O. W. Kincaid, J. R. Hodgson and M. B. Dockerty (*Am. J. Roentgenol.*, September, 1957) state that although the appearance of the primary tumour is not characteristic, the presence of an abdominal mass or a mass in the thoracic paravertebral region in a child should always suggest the diagnosis of neuroblastoma. An abdominal mass which contains calcium, particularly if the mass is in the adrenal region, will in all probability be a neuroblastoma. Radiologically, the conditions most likely to be confused with neuroblastoma are Wilms's tumour, lymphoblastoma, leukæmia, osteomyelitis, Ewing's tumour, reticuloendotheliosis and, in the thorax, benign neurogenic tumours. It is highly important that adequate X-ray examination be carried out in every case. Whenever neuroblastoma is suspected, or when an abdominal mass or skeletal lesion which is suggestive of a neuroblastoma has been found, the patient should have an X-ray examination made of all possible areas of involvement. Skiagrams of the abdomen, thorax, spinal column, skull and long bones should constitute the minimal examination. Since neuroblastoma frequently presents as an abdominal mass, the problem of differentiation from Wilms's tumour arises. Both Wilms's tumour and neuroblastoma occur in the same age group and in the same general region of the abdomen. The X-ray appearance of the primary abdominal tumour in both conditions is seldom such that a specific diagnosis can be made. Differentiation in the absence of metastases is often impossible, but several points may be helpful. Calcification within the tumour, when present, is one of the most important differential signs. It is seen in a third of all cases of abdominal neuroblastoma, but is extremely rare in Wilms's tumour. Pulmonary metastases are common in patients with Wilms's tumour and occur early, whereas in patients with neuroblastoma pulmonary lesions are relatively rare and tend to occur late, after skeletal lesions have developed. Neuroblastoma involving the skeleton is probably more often confused radiologically with leukæmia than with any other condition. In the occasional case of neuroblastoma in which the full length of the shaft of a long bone is involved without cortical destruction, and with or without the parallel type of periosteal reaction, differentiation from leukæmia may be difficult. In most cases, however, these two conditions can be differentiated on the basis of the skeletal changes. The generalized skeletal demineralization seen in patients with leukæmia is not often found in those with neuroblastoma. In patients with neuroblastoma, the changes will be confined to those bones involved by metastatic lesions; the remainder of the skeleton will appear normal. In patients with leukæmia the bone changes are usually purely destructive, in contrast to the mixed destructive and hypertrophic changes seen in the majority of patients with neuroblastoma. The transverse bands of radiolucency which are seen in leukæmic patients just beneath the epiphyses of the long bones are never seen in patients with neuroblastoma. The similar appearance of skeletal neuroblastoma and Ewing's tumour has been noted by several authors. Ewing's tumour may spread to involve several bones, and the resulting cortical destruction and periosteal reaction may closely simulate the picture seen in neuroblastoma. In most instances, however, differentiation will not be difficult. Ewing's tumour usually presents as a solitary bone lesion, most often seen in the mid-shaft. Neuroblastoma rarely occurs as a solitary bone lesion, and when it does the lesion is very small, as it has little opportunity to grow before other metastatic lesions appear in bone.

The Angled Postero-Anterior Projection of the Stomach.

S. S. Gordon (*Radiology*, September, 1957) suggests a new projection to obtain better views of the high transverse stomach. This type of stomach is the most difficult to examine. In the first place, it is most frequently encountered in the very obese patient, in whom fluoroscopic visualization is difficult on account of body thickness alone. In the second place, it lies under the costal margin, and is therefore inaccessible to palpation. Even more troublesome is the fact that there is considerable overlapping of the various portions of a stomach thus situated, so that fairly large segments may be completely obscured from clear observation. With this problem in mind, the author has utilized a new projection to minimize the amount of overlapping of the various portions of the stomach. This projection has the virtue of "opening up" the stomach, so to speak, by projecting the fundus and upper portion of the body (proximal segment) upward, and the antrum and lower portion of the body (distal segment) downward, so that the appearance is much the same as in the ordinary sthenic individual. The patient is positioned in precisely the same manner as for the routine postero-anterior projection of the stomach. A 14 inches by 17 inches cassette in the Bucky tray is pushed upward so that its upper end is at the level of the chin. The tube is tilted 45° toward the head and centred to the middle of the cassette. The target-film distance is 36 inches. Average technical factors are 100 kilovolts, 200 milliamperes, 0·6 second.

The Biliary Tract in the Normal Patient and After Cholecystectomy.

F. G. Anderson (*Am. J. Roentgenol.*, October, 1957) compares the value of the oral and intravenous methods of examining the biliary tract. The intravenous injection of "Biligrafin" has been found to improve visualization of the gall-bladder sufficiently well to make a diagnosis in a number of cases in which "Telepaque" has only faintly outlined the viscus. In jaundiced patients, although there is no contraindication to the use of "Biligrafin", the results are of little diagnostic value. The range of the diameter of the common bile duct in a normal biliary tract as seen by intravenous cholecystangiography is from seven to nine millimetres. On reviewing the evidence presented, the author finds some grounds for doubting whether physiological dilatation of the biliary ducts occurs after cholecystectomy in the human subject.

Œsophageal Webs.

H. K. Waldmann and A. Turnbull (*Am. J. Roentgenol.*, October, 1957) report four cases of œsophageal webs. The ætiology is discussed and it is believed that webs occur congenitally, in connexion with the Plummer-Vinson syndrome, and in connexion with other not definitely known causes. Clinically, the chief complaint is dysphagia, which depends partly on the degree of obstruction and partly on spastic factors. Small simple post-cricoid webs may cause no symptoms at all. Some patients note only that they have to chew more thoroughly and have to eat more slowly. With rapid swallowing, food and liquids tend to dam back and may cause overflow into the larynx and trachea, resulting in severe paroxysms of choking and coughing. Regurgitation of food is not uncommon, and the patients are frequently referred to the radiological department under the clinical diagnosis of pharyngo-œsophageal diverticulum. In cases which are believed to be congenital in origin, it is quite usual for some individuals to reach adolescence without seeking medical advice. In these cases the lesion is often detected after food impaction has occurred. However, all patients state that they have always eaten slowly throughout their lives and that they required much longer time for their meals than other people. The radiological examination of the upper part of the œsophagus is somewhat difficult, owing to the rapid passage of barium. A relatively thick paste should be used, and rapid exposures after swallowing are essential. Webs are easily overlooked and can hardly be recognized on fluoroscopy unless considerable obstruc-

tion is present or unless there is retention of barium between the webs of a double membrane. Multiple antero-posterior and lateral skiagrams should be obtained, and it is important to realize that webs are usually seen only in the active phase of deglutition, with the lower part of the pharynx and the upper part of the œsophagus fully distended. The webs appear as thin and sharply defined membranes, which protrude into the lumen from the anterior wall of the lower part of the pharynx or the upper part of the œsophagus, usually at the level of the crico-pharyngeus muscle and rarely below the level of the sternal notch, with the exception of the congenital bands which are often seen at the level of the carina. Occasionally webs surround the entire lumen or appear as a double web membrane. The smooth indentation of the crico-pharyngeus muscle should not be mistaken for a web; it always indents the posterior wall of the upper part of the œsophagus, and the indentation disappears during the Valsalva manœuvre. In the majority of cases, dilatation of the œsophagus by bougies is sufficient to enlarge the lumen and is followed by disappearance of the web. Occasionally it is necessary that the web be incised in order to permit passage of the dilators. If anæmia is present, iron therapy is indicated.

RADIOTHERAPY.

Modified Collimator for Total Body Scanning.

J. P. CONCANNON AND F. BOLHUIS (*Am. J. Roentgenol.*, November, 1957) point out that in the therapeutic treatment of thyroid carcinoma with I^{131} it is necessary to demonstrate that there is a selective acquisition of I^{131} by tumour tissue. Total body scanning after tracer doses of I^{131} gives information as to the localization of iodine within the body, and is useful not only as a first measure, but for comparisons of uptake after subsequent therapeutic doses of radioactive iodine. With the usual type of scintillation counter, scanning is done along four parallel lines counting at five-centimetre intervals. This is a lengthy procedure, and in this paper an inexpensive collimator is described which has a wide angle of vision laterally and reduces the time of body scanning.

Radiotherapy in Carcinoma of the Cervix.

E. HARRISON (*Proc. Coll. Radiologists Australasia*, June, 1957) presents the results of 361 cases of cervical carcinoma treated at the Queensland Radium Institute between 1945 and 1950. In the early cases intracavitary radium therapy alone was employed, in accordance with the Manchester technique, to a dose of 7000*r* at point A. When supplementary deep X-ray therapy was given, this dose was reduced to 6500*r*. In the late stage III and IV cases, deep X-ray therapy alone was given, but when practicable, radium was always used. No patient died directly as a result of treatment. Five patients developed a late rectal reaction, and six developed a fistula. All these had carcinomatous extension to the vagina. Of the 361 cases, 28% were stage I; 33% were stage II; 26% were stage III; 7% were stage IV; and 6% were unclassified. The five-year survival rate among stage I patients was 63%; among stage II patients it was 49%; among stage III patients 26%; and among stage IV patients 4%. There were no survivors among the unclassified patients. The overall five-year survival rate was 43%.

Radioisotopes in Gastro-Intestinal Function.

G. J. BAYLIN *et alii* (*Am. J. Roentgenol.*, October, 1957) report that a fat meal tagged with radioiodine (I^{131} glycerol trioleate) has been used in the study of fat digestion and absorption. The technique is discussed and a series of normal subjects gave uniform reproducible levels of radioactivity in both blood and fæces. Application of the test to abnormal patients has shown it to be of clinical value in pancreatic disease, in diseases of the small intestine and in some post-operative cases. It has been used to gauge the effectiveness of certain treatments and offers a practical advance in the evaluation of fat absorption in the gastro-intestinal tract. The estimation of fæcal radioactivity constitutes a new type of fat absorption study.

DERMATOLOGY.

Kerion Celsi.

W. R. HUBLER (*Arch. Dermat.*, August, 1957) states that for four years he has treated all patients with *kerion celsi* with applications of solid carbon dioxide, using a pencil of approximately 2·0 to 2·5 centimetres in diameter, and applying it firmly for 25 seconds to a sufficient number of areas to cover the kerion and a 0·5 centimetre margin around it. The lesions become quite œdematous, but subside in a few days with hot compresses and an antibiotic ointment. In about 10 days the kerion is completely healed. An occasional lesion requires additional treatment to one or two small areas two weeks after the initial treatment. Hair regrowth is normal.

Mycosis Fungoides Treated with Antimony.

J. GARB (*Arch. Dermat.*, October, 1957) reports the cure of three patients with tumour and infiltrated stages of *mycosis fungoides* treated with antimony salts. There was no sign of recurrence five to eight years after completion of the original treatment. A recent biopsy specimen taken from a pigmented spot on the left leg of one patient showed completely normal skin, in contrast to the specimen taken from the identical area in November, 1948, which had shown the histological features of *mycosis fungoides*. The therapeutic effect of antimony on the three patients had been termed specific because of the strikingly rapid and progressive response of the tumours and infiltrated growths to this metal. The author believes that in clear-cut cases, *mycosis fungoides* should show unequivocal response to antimony (tartar emetic given intravenously or stibophen given intramuscularly as a second choice) within six to eight weeks. In the first case quoted the patient responded dramatically to 10 intravenous injections of 1·0% tartar emetic, each of five millilitres, given three times a week. This course was followed by 73 injections of "Stibanose" (the diethylaminoethanol salt of sodium antimony gluconate) and 42 injections of stibophen. This patient received a total of 7·80 grammes of antimony.

Cutaneous Moniliasis.

A. G. DUNCAN (*Arch. Dermat.*, October, 1957) states that problems connected with Candida infections, especially those of the skin, have come to the fore since the advent of broad-spectrum antibiotics. Cutaneous moniliasis following the local application of antibiotics for pyoderma has been described by various authors. They were of the opinion that the infection occurred only after prolonged therapy. It has been proved that axillary odour is produced by bacterial action on apocrine sweat. Commercial deodorants are effective because they are bactericidal, though they also have a chemical action which neutralizes odours already present. Robinson found that 16% of patients who had received penicillin or broad-spectrum antibiotics recently or some months before had positive cultures of *Candida albicans* from their oro-pharynx and stools. There would seem little doubt that cutaneous moniliasis is at least somewhat commoner since the introduction of the broad-spectrum antibiotics. A case of cutaneous moniliasis is reported in which *C. albicans* was cultured from the scales. It occurred on normal skin following the daily application of an antibiotic salve used as a deodorant. Prompt healing followed the application of nystatin ointment. The patient was proved to be a carrier of *C. albicans* in his nose, throat and gastro-intestinal tract. He had a history of *pruritus ani* on three different occasions following a course of antibiotics taken by mouth for acute sinusitis.

Hydrocortisone in Necrobiosis Lipoidica Diabeticorum.

R. H. MARTIN AND M. DULAKE (*Brit. J. Dermat.*, November, 1957) report that injections of hydrocortisone acetate in normal saline containing 0·3% sodium carbomethyl cellulose were compared with control injections of the base alone in the treatment of *necrobiosis lipoidica diabeticorum*. The hydrocortisone solution was made up in strengths of 25 and 50 milligrammes per millilitre. The volume of solution injected depended on the size of the lesion and varied from 0·05 millilitre to 2·0 millilitres. The amount required often decreased as improvement took place. Each injection was made through normal skin, the needle then being directed into the lesion. A tuberculin syringe with a number 20 gauge needle was used for smaller lesions, a number 16 gauge needle being used for the larger ones. Injections were given at weekly intervals, the number varying between one and 12. Of the 18 lesions treated, 17 showed marked retrogression or complete resolution and one was slightly reduced.

British Medical Association.

VICTORIAN BRANCH: ANNUAL MEETING.

THE annual meeting of the Victorian Branch of the British Medical Association and the Medical Society of Victoria was held at the Medical Society Hall, Albert Street, East Melbourne, on December 4, 1957, DR. ALAN MCCUTCHEON, the President, in the chair.

MINUTES.

The minutes of the annual meeting held on December 5, 1956, were taken as read and signed as correct.

ELECTION OF OFFICE-BEARERS.

The Medical Secretary announced that the Council had elected the following office bearers for 1958.

President: Dr. Keith Hallam.

Vice-Presidents: Dr. J. Gavin Johnson and Dr. H. G. Judkins.

Honorary Secretary: Dr. K. E. Ratten.

Honorary Treasurer: Dr. Leonard Ball.

Honorary Librarian: Dr. V. L. Collins.

Chairman of Council: Dr. H. C. Colville.

The Medical Secretary announced that the following had been elected members of the Council by the general body of members: Dr. Kevin Brennan, Dr. Grayton Brown, Dr. V. L. Collins, Dr. J. L. Frew, Dr. H. G. Furnell, Dr. Keith Hallam, Dr. A. M. Hutson, Dr. M. O. Kent Hughes, Dr. W. E. King, Dr. D. G. MacKellar, Dr. G. Newman-Morris, Dr. B. K. Rank, Dr. Robert Southby, Dr. Stanley Williams.

The Medical Secretary announced that the following had been elected members of the Council by the subdivisions: Dr. Leonard Ball, Dr. A. J. M. Sinclair, Dr. T. G. Swinburne, Dr. N. L. Dodd, Dr. K. E. Ratten, Dr. H. G. Judkins, Dr. H. F. Tucker, Dr. J. G. Johnson, Dr. A. W. Burton, Dr. A. B. McCutcheon, Dr. E. Sandner, Dr. G. C. Darby, Dr. M. H. Robinson, Dr. D. F. Mitchell, Dr. W. R. Angus, Dr. F. R. Phillips, Dr. D. F. Lally, Dr. B. Hutton Jones.

The Medical Secretary announced that the ex-officio members of the Council were: Dr. H. C. Colville, Dr. F. L. Davies, Sir Victor Hurley, Dr. D. Roseby, Dr. G. R. Weigall, Dr. J. P. Major. The representative of the Victorian Medical Women's Society was Dr. Leslie Williams.

ANNUAL REPORT OF THE COUNCIL.

The annual report of the Council, which had been circulated among members, was received and adopted. The report is as follows.

The Council of the Branch and the committee of the Society present the seventy-eight annual report of the Branch and the one hundred and second of the Society.

Election.

At the annual meeting held last December, the following members of the Council and of the committee were elected, following a ballot of members of the Branch: Dr. Kevin Brennan, Dr. Grayton Brown, Dr. V. L. Collins, Dr. J. L. Frew, Dr. H. G. Furnell, Dr. Keith H. Hallam, Dr. A. M. Hutson, Dr. M. O. Kent Hughes, Dr. W. E. King, Dr. D. G. MacKellar, Dr. G. Newman-Morris, Dr. B. K. Rank, Dr. Robert Southby and Dr. Stanley Williams.

The following were elected to represent the subdivisions: Dr. W. R. Angus, Dr. L. H. Ball, Dr. A. W. Burton, Dr. D. A. Carter, Dr. N. L. Dodd, Dr. J. Gavin Johnson, Dr. B. Hutton Jones, Dr. H. G. Judkins, Dr. D. F. Lally, Dr. A. B. McCutcheon, Dr. D. F. Mitchell (elected after the retirement of Dr. A. B. Hewitt), Dr. F. R. Phillips, Dr. K. E. Ratten, Dr. M. H. Robinson, Dr. E. Sandner, Dr. A. J. M. Sinclair, Dr. T. G. Swinburne, Dr. H. F. Tucker (elected during the year to take the place of Dr. G. R. Weigall, who was appointed a trustee of the Medical Society of Victoria).

Under Rule 9 of the Branch, Council elected Dr. Leslie Williams, who was nominated by the Victorian Medical Women's Society.

The following are ex-officio members: the trustees of the Medical Society of Victoria, Dr. H. C. Colville, Dr. F. L. Davies, Sir Victor Hurley, Dr. D. Roseby, Dr. G. R. Weigall (appointed following the death of Sir John Newman-Morris), and the director for Victoria of the Australasian Medical Publishing Company, Limited, Dr. J. P. Major.

Coopted member: Major-General W. D. Refshauge.

The Council elected the following office bearers:

President: Dr. Alan McCutcheon.

Vice-Presidents: Dr. Keith H. Hallam and Dr. J. Gavin Johnson.

Chairman of Council: Dr. H. C. Colville.

Honorary Treasurer: Dr. Leonard H. Ball.

Honorary Librarian: Dr. V. L. Collins.

Honorary Secretary: Dr. G. Newman-Morris.

Past President: Dr. George Swinburne.

The Executive consisted of the President, the Immediate Past President (Dr. George Swinburne) and the other office bearers.

Attendances at Council Meetings.

Thirteen meetings of the Branch Council were held, the following showing the attendances:

Dr. J. Gavin Johnson	13	Dr. B. K. Rank	9
Dr. A. B. McCutcheon	13	Dr. J. L. Frew[2]	8
Dr. David Roseby	13	Dr. J. P. Major	8
Dr. L. H. Ball	12	Dr. F. R. Phillips	8
Dr. A. W. Burton	12	Dr. Stanley Williams	8
Dr. H. C. Colville	12	Dr. Grayton Brown	7
Dr. Robert Southby	12	Dr. H. G. Judkins[2]	7
Dr. T. G. Swinburne	12	Dr. W. E. King	7
Dr. Leslie Williams	12	Dr. M. Robinson	7
Dr. Keith H. Hallam	11	Dr. H. G. Furnell[2]	6
Dr. K. E. Ratten	11	Dr. D. G. MacKellar	6
Dr. E. Sandner	11	Dr. D. A. Carter[3]	5
Dr. G. Raleigh Weigall	11	Major-General W. D. Refshauge	5
Dr. Kevin Brennan	10	Dr. A. J. M. Sinclair[3]	4
Dr. F. L. Davies	10	Dr. W. R. Angus	3
Dr. N. L. Dodd	10	Dr. B. Hutton Jones	3
Dr. M. O. Kent-Hughes	10	Dr. D. F. Mitchell[3]	3
Dr. D. F. Lally	10	Dr. H. F. Tucker[3]	3
Dr. G. Newman-Morris	10	Sir Victor Hurley	1
Dr. V. L. Collins	9	Dr. A. B. Hewitt[1]	0
Dr. A. M. Hutson	9		

Dr. L. T. Griffiths attended one meeting as proxy for Dr. Angus; Dr. M. Clarke attended one meeting as proxy for Dr. Sandner; and Dr. F. P. McArdle and Dr. N. F. Pescott each attended one meeting as proxy for Dr. Robinson.

The highest attendance at any one meeting was 34, and the average attendance was 27.

Subcommittees of the Branch Council.

Complaints.—Dr. Davies, Dr. Judkins, Dr. McCutcheon, Dr. Newman-Morris and Dr. Roseby.

Correspondence.—Dr. Colville and Dr. Newman-Morris.

Ethics.—Dr. Major, Dr. Davies, Dr. Judkins, Dr. King, Dr. Roseby, Dr. Southby, Dr. Weigall and the Executive.

Finance, House and Library.—Dr. Ball, Dr. Furnell, Dr. Collins, Dr. Kent-Hughes and Dr. Judkins.

Health Education.—Dr. Roseby, Dr. Brennan, Dr. Hutson, Dr. Rank, Dr. Judkins and Dr. Leslie Williams.

Hospital.—Dr. Southby, Dr. Ball, Dr. Brennan, Dr. Collins, Dr. Colville, Dr. Dodd, Dr. Frew, Dr. Hallam, Dr. Judkins, Dr. Kent-Hughes, Dr. King, Dr. Rank, Dr. Weigall and Dr. Stanley Williams.

Information Service.—Dr. Newman-Morris, Dr. Collins, Dr. Brennan, Dr. Phillips, Dr. Rank and Dr. Kent-Hughes.

Legislative.—Dr. Davies, Dr. Colville, Dr. Hallam, Dr. Rank and Dr. Sinclair.

Organization.—Dr. Swinburne, Dr. Ball, Dr. Brennan, Dr. Colville, Dr. Dodd, Dr. Frew, Dr. Furnell, Dr. Hutson, Dr. Johnson, Dr. Judkins, Dr. Kent-Hughes, Dr. McCutcheon, Dr. Rank, Dr. Ratten, Dr. Roseby, Dr. Sinclair, Dr. Southby, Dr. Weigall, Dr. Leslie Williams and representatives of the country subdivisions.

Science.—Dr. Hallam, Dr. Grayton Brown, Dr. Collins, Dr. King, Dr. Stanley Williams and Dr. Furnell.

Social.—Dr. Roseby, Dr. Weigall and Dr. Burton.

Workers' Compensation.—Dr. Ball, Dr. Grayton Brown, Dr. Kent-Hughes, Dr. Newman-Morris, Dr. Judkins, Dr. Rank, Dr. Roseby and Dr. Colville.

Special Committees and Offices Within the Branch.

Building Committee.—The President, the Honorary Treasurer, the Honorary Secretary and Sir Albert Coates.

[1] Resigned during the year.

[2] Granted leave of absence during the year.

[3] Elected during the year.

Federal Medical War Relief Fund Advisory Committee.—Dr. F. L. Davies, Dr. H. G. Furnell and Dr. W. G. D. Upjohn.

Joint Committee with Health Department re Spheres of Responsibility for Medical Services to the Community.—The President, Dr. G. Newman-Morris, Dr. A. J. M. Sinclair, Dr. V. L. Collins and Dr. T. G. Swinburne.

Library Advisory Committee.—The Honorary Librarian, Dr. J. H. W. Birrell, Dr. B. Gandevia, Dr. H. Boyd Graham, Dr. T. A. F. Heale, Dr. J. W. Johnstone, Dr. R. S. Lawson, Dr. Murray Maxwell and Dr. M. L. Verso.

Limitation of Number of Medical Students.—The President, Dr. M. O. Kent-Hughes, Dr. H. G. Furnell, Dr. K. E. Ratten and the Medical Secretary.

Medical Officers' Relief Fund (Federal) Advisory Committee.—Dr. F. L. Davies, Dr. H. G. Furnell and Dr. W. G. D. Upjohn.

Medical Society of Victoria, Trustees of.—Dr. H. C. Colville, Dr. F. L. Davies, Sir Victor Hurley, Dr. D. Roseby and Dr. G. Raleigh Weigall.

Museum Advisory Committee.—The Honorary Librarian, the Curator, Dr. J. H. W. Birrell and Dr. M. L. Verso.

Negotiating Committee, Salaried Appointments in Hospitals.—Dr. T. G. Swinburne, Dr. G. Newman-Morris, Dr. H. C. Colville, Dr. K. H. Hallam, Dr. H. G. Judkins, Dr. Robert Southby, Dr. L. H. Ball and Dr. A. J. M. Sinclair.

Services Recognition Fund, Trustees of.—Sir Albert Coates, Dr. H. G. Furnell and Major-General Sir Kingsley Norris.

World Medical Association Supporting Committee.—Dr. D. Roseby, Dr. K. H. Hallam, Dr. B. K. Rank, Dr. A. J. M. Sinclair and Dr. Stanley Williams.

Appointments and Nominations.

Anti-Cancer Council of Victoria.—Dr. J. E. Clarke and Dr. H. Searby.

Anti-Cancer Council, Medical and Scientific Committee of.—Professor Maurice Ewing.

British Medical Association, Annual Representative Meeting, Newcastle-on-Tyne, 1957.—Dr. Ian L. McVey and Dr. B. D. Vaughan.

British Medical Association, Central Council.—Dr. M. L. Formby.

British Medical Association in Australia, Federal Council.—Dr. H. C. Colville, Dr. Robert Southby and Dr. J. G. Johnson.

British Medical Agency of Victoria, Proprietary, Limited.—Directors: Dr. C. H. Dickson (Chairman), Dr. Leonard Ball, Major-General Sir Kingsley Norris and Dr. Robert Southby.

British Medical Insurance Company of Victoria, Limited.—Directors: Sir Victor Hurley (Chairman), Dr. C. H. Dickson, Dr. H. G. Furnell, Dr. W. W. S. Johnston, Major-General Sir Kingsley Norris and Dr. G. Newman-Morris.

Central Medical Library Committee.—Dr. V. L. Collins.

Clinical Material for Student Teaching.—Dr. B. K. Rank and Dr. George Swinburne.

Conjoint Committee with the Friendly Societies' Association of Victoria.—Dr. Charles Byrne, Dr. C. H. Dickson and Dr. J. G. Johnson.

Consultative Council on Influenza.—Professor J. G. Hayden.

Consultative Council on Maternal Mortality.—Dr. J. G. Johnson.

Consultative Council on Poliomyelitis.—Dr. W. G. D. Upjohn.

Consultative Council on Quarantinable Diseases.—Dr. P. Gilbert.

Dietetic Association of Victoria.—Dr. T. A. F. Heale.

Fellowship of Christian Healing.—Dr. A. Murray Clarke, Dr. Arthur J. Day, Dr. J. G. Johnson, Dr. H. G. Judkins, Dr. R. Southby and Professor Lance Townsend.

Fluoridation of Water Supplies, Advisory Panel to Health Department.—Dr. L. P. Wait.

Hæmophilia Society.—Dr. R. J. Sawers.

Health (Proprietary Medicines) Act, Advisory Committee under the Provisions of.—Dr. Byron L. Stanton.

Hospital Benefits Association of Victoria.—Dr. C. H. Dickson, Major-General Sir Kingsley Norris, Dr. H. G. Judkins and Dr. G. R. Weigall.

Hospitals and Charities Commission, Advisory Council to.—Dr. L. H. Ball and Dr. C. H. Dickson.

Joint Insurance Adjudication Committee.—Dr. L. H. Ball, Dr. D. Roseby and Dr. W. G. D. Upjohn.

Lord Mayor's Fund.—Dr. R. D. Aitchison.

Lord Mayor's Country Children's Holiday Camp, Committee of.—Dr. Gwynne Villiers.

Masseurs' Registration Board.—Dr. Bryan Keon-Cohen and Dr. Leigh T. Wedlick.

Certification of Death (Cremation), Special Committee with Commission of Public Health and Law Department.—Dr. C. H. Dickson.

"The Medical Journal of Australia", Victorian Correspondent.—Dr. C. H. Dickson.

Medico-Pharmaceutical Liaison Committee.—Dr. W. E. King, Dr. D. Roseby, Dr. Byron Stanton, the President (*ex officio*) and the Medical Secretary.

Melbourne Medical Postgraduate Committee.—Dr. J. P. Major and Dr. G. R. Weigall.

National Committee of British Commonwealth Collection of Microorganisms.—Professor S. D. Rubbo.

National Safety Council of Australia.—Dr. Kevin Brennan.

Nursing Aide School, Committe of Management.—Dr. G. R. Weigall.

The Occupational Therapy School of Victoria.—Dr. D. O. Longmuir.

Old People's Welfare Council.—Dr. A. B. McCutcheon and Dr. W. W. S. Johnston.

Opticians' Registration Board.—Dr. John Bignell and Dr. R. F. Lowe.

Pensioner Medical Service, Committee of Inquiry.—Professor J. G. Hayden, Dr. C. Byrne, Dr. J. G. Johnson and Dr. M. O. Kent-Hughes.

Red Cross Blood Transfusion Service, Advisory Committee.—Dr. Charles Byrne.

Rehabilitation Medical Advisory Committee, Victoria (Social Services Department).—Dr. J. Cuming Stewart.

Rotary Club (Citizens' Committee).—The President of the Branch.

Royal Flying Doctor Service of Australia.—Dr. George Simpson.

State Medical Planning Committee.—Dr. H. G. Furnell.

Victorian Baby Health Centres' Association.—Dr. Stanley Williams.

Victorian Bush Nursing Association.—Dr. E. McComas.

Victorian Council of Speech Therapy.—Dr. Robert Southby.

Victorian Documentary Film Council, Advisory Committee on Scientific Films.—Dr. Morris Davis and Dr. R. S. Hooper.

Victorian Health Week Committee.—Dr. D. Roseby.

Victorian Nursing Council.—Dr. W. M. Lemmon and Dr. J. L. Frew.

Victorian Society for Crippled Children.—Dr. John Cloke.

Branch Convocation.

The following were elected for the year 1957.—*Melbourne Central*: Dr. C. J. O. Brown, Dr. J. Eric Clarke, Dr. E. E. Dunlop, Dr. H. C. Fitts, Dr. H. Boyd Graham, Dr. T. A. F. Heale, Dr. R. S. Lawson, Dr. Kate Mackay, Dr. J. O'Sullivan, Dr. G. Penington, Dr. H. A. Phillips, Dr. S. Reid, Dr. C. A. M. Renou, Dr. J. E. Sewell, Dr. Norman L. Speirs, Dr. Guy Springthorpe, Dr. G. M. Tallent. *Eastern Suburban*: Dr. R. D. Bartram, Dr. W. H. Coates, Dr. H. Enniss, Dr. H. V. Francis, Dr. A. F. Griffiths, Dr. A. L. Hare, Dr. H. J. Hosking, Dr. H. H. Jackson, Dr. P. G. McMahon, Dr. N. McH. Ramsey, Dr. W. R. Rigg, Dr. J. G. Simpson, Dr. T. Stokoe, Dr. K. W. Summons, Dr. R. D. Watson. *Northern Suburban*: Dr. F. A. L. Bacon, Dr. D. Cordner, Dr. J. E. Dunn, Dr. R. Gurry, Dr. D. C. Lear, Dr. H. R. Walker, Dr. I. A. Wilson, Dr. I. D. Wilson. *North Eastern Suburban*: Dr. C. M. Greer, Dr. L. J. Hartman, Dr. W. Heslop, Dr. B. H. McColl Dr. C. F. MacGillicuddy. *Southern Suburban*: Dr. J. H. Body, Dr. D. L. Collie, Dr. A. Ley, Dr. L. Middleton, Dr. A. O. Rosenhain, Dr. R. S. Smibert. *South Central Suburban*: Dr. D. J. M. Dunn, Dr. E. A. C. Farran, Dr. J. Smibert, Dr. Q. J. Whitehead, Dr. C. W. Wilson, Dr. R. D. Wilson. *South Eastern Suburban*: Dr. J. F. Adamson, Dr. J. F. Akeroyd, Dr. James Best, Dr. R. D. Buntine, Dr. J. Clough, Dr. J. V. C. De Crespigny, Dr. C. C. Dyte, Dr. D. I. Hart, Dr. H. N. Luth, Dr. R. Y. Mathew, Dr. G. W. Patterson. *Western Suburban*: Dr. D. D. Coutts, Dr. A. H. Green, Dr. L. Gurry, Dr. R. H. Hardy. *Ballarat*: Dr. G. R. Davidson, Dr. G. T. James, Dr. E. Sheil. *Bendigo*: Dr. N. N. Harrington, Dr.

W. J. Long, Dr. A. L. Newson. *Geelong*: Dr. D. A. Kidd, Dr. L. D. Renouf. *Gippsland*: Dr. Alan Crook, Dr. W. F. Ferguson, Dr. J. M. Andrew. *Goulburn*: Dr. F. V. Harder, Dr. R. O. Mills. *North Eastern Country*: Dr. H. Marks, Dr. M. Rohan. *North Western Country*: Dr. A. Hinchley, Dr. T. Walpole, Dr. R. Webster. *South Western Country*: Dr. A. E. Brauer, Dr. S. Fitzpatrick, Dr. B. D. Vaughan.

Membership Roll.

The number of members on the roll at October 24, 1957, was 2995, which was 115 more than last year. Three hundred and four members were added (144 by election, 64 were reinstated on payment of arrears, and 96 were transferred from other States and overseas), and 189 names were removed (22 by death, 77 by transfer, 13 by resignation, and 77 allowed their subscriptions to fall into arrears).

Honorary medical members number 40, and there is one complimentary member.

Honorary student associates number 47.

Deceased.

The deaths of the following members and former members occurred during the year and are recorded with regret: Dr. A. A. Altmann, Dr. F. R. Cawthorn, Dr. N. Chenhall, Dr. W. A. Forshaw, Dr. R. L. Forsyth, Dr. D. L. Gundry, Dr. L. J. T. Hartnett, Dr. H. H. Henshall, Dr. H. M. Hewlett, Dr. E. R. Hurley, Dr. H. Jacks, Dr. Isaac Jones (former representative of the Branch on the Central Council, British Medical Association, London), Dr. W. E. Jones, Dr. I. M. King Scott, Dr. F. E. Littlewood, Dr. P. J. Longmore, Dr. W. C. McClelland, Dr. S. A. McKenzie, Dr. C. I. McLaren, Dr. A. H. Melville, Dr. H. W. F. Mitchell, Sir John Newman-Morris, Dr. L. M. Routh, Dr. M. H. Southwick, Dr. J. F. Spring, Dr. J. P. Spring, Dr. C. Stephen, Dr. Clara Stone, Dr. A. H. Thwaites, Dr. L. P. Wait.

Following the death of Sir John Newman-Morris on January 3, 1957, Council passed the following Special Minute:

> The Council of the Victorian Branch of the British Medical Association records with profound regret the death of John Newman-Morris, Knight Bachelor, C.M.G., Knight of St. John, and Fellow of the Royal Australasian and American Colleges of Surgeons.
>
> His services to the medical profession as a member of the Council of the Victorian Branch of the British Medical Association and sometime its President and Chairman, as a Trustee of the Medical Society of Victoria, as a member of the Federal Council of the Association in Australia, as President of the Eighth Session of the Australasian Medical Congress, and as the Chairman of the British Medical Insurance Company, were outstanding.
>
> His membership of the Standing Committee of Convocation and of the Council of the University of Melbourne, of which he was for a period Deputy Chancellor, his Presidency of the Medical Board of Victoria, of the St. John Ambulance Association and of the Australian Red Cross Society exemplify his services to education and the community, but the naming of those offices does no more than reveal a small number of the offices he held in organizations devoted to the welfare of the people of Victoria.
>
> Council extends its sympathy to his son and daughter, Dr. Geoffrey Newman-Morris and Mrs. Standish.

Death of Dr. Mervyn Archdall.

Dr. Mervyn Archdall died in Sydney on September 6. Although he was not a member of the Victorian Branch, his death was a personal matter to a great number of people here. Apart from the outstanding service he gave to the profession as editor of THE MEDICAL JOURNAL OF AUSTRALIA, he will be remembered by many people all over Australia as a friend, because he had a very great capacity for friendship. As a tangible appreciation of his services to the profession the Federal Council awarded him the Gold Medal of the Association only a few days before his death.

Appointment of Editor to "The Medical Journal of Australia".

On the retirement of Dr. Archdall on August 31, Dr. Ronald Winton was appointed Editor of THE MEDICAL JOURNAL OF AUSTRALIA. The Branch's congratulations and good wishes for the future are extended to him.

Remembrance Day.

In the presence of members of the Branch and relatives of deceased medical officers, a short ceremony was held in the foyer of the Medical Society Hall on Monday, November 11, 1957, to honour the Victorian medical officers who lost their lives in the service of the Commonwealth in the two world wars of this century. After the Medical Secretary had read the names of those killed on service and of those who had died while serving, the President laid a wreath on the War Memorial.

Church Services.

The eighth annual church services for the medical profession were held on Sunday, February 10, 1957, in St. Paul's Cathedral and St. Patrick's Cathedral. Members and medical students assembled in the precincts of the cathedral and entered in procession.

At St. Paul's Cathedral the sermon was preached by the most reverend the Archbishop Administrator, the Reverend Dr. J. J. Booth, C.M.G., M.C., and at St. Patrick's Cathedral the preacher was the Reverend Father John Phelan, Chaplain at the Royal Melbourne Hospital.

At St. Paul's Cathedral the President, Dr. A. B. McCutcheon, and the Vice-President, Dr. Keith H. Hallam, read the lessons.

Congratulations.

During the year the Branch Council had pleasure in congratulating the following: Major-General Sir Frank Kingsley Norris, K.B.E., C.B., D.S.O., E.D., on being created a Knight of the British Empire; Professor Sir Arthur Amies, C.M.G., and Professor Sir Gordon Cameron (England) on being created Knights Bachelor; Dr. Archie S. Anderson, C.B.E., Dr. P. L. Bazeley, C.B.E., Dr. Benjamin T. Edye, C.B.E. (N.S.W.), Dr. J. G. Hunter, C.M.G. (General Secretary of the Federal Council of the British Medical Association in Australia), Surgeon Rear-Admiral Lionel Lockwood, M.V.O., D.S.C., Q.H.P., C.B.E., Dr. George Simpson, O.B.E., and Dr. R. Whishaw, C.B.E. (Tasmania), as the recipients of honours conferred on them by Her Majesty Queen Elizabeth II; and Professor R. J. A. Berry (England), sometime Professor of Anatomy in the University of Melbourne, on the celebration of his ninetieth birthday.

Golf.

The eighteenth annual golf tournament of the Branch was held on Thursday, November 15, 1956, on the East Course of the Royal Melbourne Golf Club. Dr. K. B. Brown won the Weigall Cup (championship), and the Roseby Cup (handicap) was won by Dr. A. D. Wilson. The spoon competition was won by Dr. E. D. O'Brien and Dr. C. G. Shaw.

Entertainment.

On behalf of the Council the President welcomed the new medical graduates into the profession on December 19, 1956, after which they were entertained at afternoon tea by members of Council. The supplementary graduates were welcomed by the President and Council on April 9, 1957.

In February, Dr. Frank G. Dickinson, Ph.D., Director of the Bureau of Medical Economic Research of the American Medical Association, visited Melbourne during a world tour. The office arranged for him to meet a number of people whom he wished to interview in connexion with a research project on demography in which he was engaged, and on February 21 the Council entertained him at a very happy late afternoon party in the Council Room.

On Wednesday evening, April 17, members visited the National Gallery of Victoria at the invitation of the Director, who took them over the Gallery.

Following the Queen's Birthday Honours awarded in June, a complimentary dinner was given at the Union House on September 12 by the Council to Major-General Sir Kingsley Norris, K.B.E., C.B., D.S.O., E.D., Professor Sir Arthur Amies, C.M.G., and Dr. Archie S. Anderson, C.B.E.

On Friday, October 25, the President entertained members of Council and their wives and representatives of other organizations at a buffet dinner at the Union House

Meetings of the Branch.

The following meetings of the Branch were held in Melbourne:

February.—Professor Sydney Sunderland, Dean of the Faculty of Medicine, University of Melbourne, spoke on "Medical Education".

April.—Dr. Keith H. Hallam, who had recently returned from abroad, where he had represented the Branch at the

1956 annual meeting of the Association, gave an illustrated talk entitled "A Medical Travelogue".

May.—Dr. J. Bryant Curtis spoke on "Trauma and the Subdural Space", following which Sir James Paterson Ross, Sims Travelling Professor for 1957, opened the discussion.

July.—At a meeting on July 3, members of the Consultative Council on Maternal Mortality gave a report of their first three years of work; and at a meeting on July 17 Dr. Robert Officer showed films taken on a visit to China.

August.—Dr. Robert H. Orton delivered the ninth Embley Memorial Lecture entitled "The Influences of Physiology and Pharmacology on the Advancement of Anæsthesia".

September.—Professor Maurice Ewing, Professor of Surgery in the University of Melbourne, spoke on "Odd Skin Tumours".

October.—Sir Daryl Lindsay, LL.D., delivered the twenty-fourth Sir Richard Stawell Oration, entitled "Five Men: Hamilton Russell, Henry Simpson Newland, Henry Tonks, Fay Maclure, Robert Charles Lindsay".

November.—A symposium was arranged by the Section of Industrial Medicine on "The General Practitioner in Relation to Industry", at which Mr. Ferguson Laidlaw spoke on "Industrial Medical Legislation and General Practice", Dr. W. F. Cooper on "General Practitioner-Patient-Industrial Medical Officer", Dr. A. Christophers on "Facilities in Victoria for the Medical Measurement of Environment", and Dr. M. O. Kent-Hughes on "The Problems of General Practice and Industry".

The following demonstrations and clinical meetings were held in Melbourne:

February.—Footscray and District Hospital.

June.—The Royal Melbourne Hospital.

September.—The Pathology Department, University of Melbourne.

October.—St. Vincent's Hospital.

The following meetings were held in the country:

March.—Hamilton. Clinical cases were presented at the Hamilton Base Hospital in the afternoon, and in the evening Professor R. R. H. Lovell, Professor of Medicine in the University of Melbourne, spoke on "Treatment with Cortisone".

October.—Geelong. Clinical cases were presented in the afternoon at the Geelong and District Hospital, and in the evening Mr. B. K. Rank gave an illustrated talk on "The People of Pakistan".

The Branch Council wishes to express its appreciation and thanks to the committees and honorary secretaries of country subdivisions for arranging the country meetings, to the wives of members of the subdivisions for their hospitality to visiting members and their wives, and to the committees and matrons of the Hamilton and Geelong Hospitals for the provision of facilities.

The Branch Council also thanks the staffs of the Pathology Department, the Footscray and District Hospital, the Royal Melbourne Hospital and St. Vincent's Hospital for arranging the meetings, which were excellent.

In November the Cancer Institute Board invited all members of the Branch to a demonstration arranged by the staff of the Peter MacCallum Clinic. The demonstration, the first arranged by the clinic for the benefit of the whole profession, was very much appreciated.

Special Meeting of the Branch.

One special meeting of the Branch was called during the year. This was in regard to the ethical rules of the Branch, and was held on September 4.

Early in the year the Federal Council passed a resolution revising its previous decision in regard to members appearing on television. The Federal Council resolution was in line with the public relations policy of the Branch, and the Council formulated the following new rule, for submission to a meeting of the Branch, to take the place of the rule relating to broadcasting:

> Broadcasting and Television.—Radio and television lectures shall not be given on any professional subject by any member engaged in active medical or surgical practice except with the permission of the Branch Council and under such conditions as may be imposed by the Council.

As a number of the ethical rules required revising, however, it was decided by Council that the Legislative and Ethics Subcommittees should review the rules and submit further alterations to the Branch at the same time as the above new rule was to be submitted. This was done, and the special meeting of the Branch held on September 4 passed the alterations with one minor amendment. These were listed in the monthly notice paper circulated to all members on August 23, 1957.

Business of Council.

Australasian Medical Congress, Tenth Session, March 1-7, 1958.—At the request of the committee of Congress, nominations for appointment as office bearers of sections were submitted, and Council was pleased to note that six members of the Victorian Branch have been appointed as presidents of sections.

Ethical Decisions.—During the year the Ethics Subcommittee considered two cases where disputes had arisen following commencement of practice by a former assistant in proximity to the practice of his former principal. In both cases the Subcommittee found against the assistant, and subsequently members were advised in the monthly paper of the desirability of proper legal contracts being drawn in all cases where assistants are employed.

Radiological Appointments.—After lengthy negotiations with the Hospitals and Charities Commission, and in full consultation with the College of Radiologists, an agreement was reached governing the conditions of appointment of radiologists in public hospitals. While special conditions will obtain in the teaching hospitals, appointees in other hospitals will have the choice of working under a salaried scheme with superannuation rights, etc., or may accept appointment with the right of practice with, initially and until they become established, a guaranteed income.

The Functions of State Government in Relation to Medical Services.—As it has become increasingly obvious in recent years that the Government of Victoria is assuming more and more responsibility in relation to the provision of medical care for certain sections of the community, the matter was discussed with the Minister of Health, and subsequently a Medical Liaison Committee, composed of representatives of the Branch Council and of the State Health Department, was established. This committee has met on several occasions and at each meeting one aspect of the activities of the Health Department has been examined in detail. When all the activities have been reviewed a report will be prepared, but it is apparent that the institutional care of persons suffering from mental disorders, tuberculosis, poliomyelitis and infectious diseases is now virtually a State responsibility.

Hospital Costs.—During the year the State Government, gravely concerned at the ever-rising cost of hospitals, appointed a Committee of Inquiry, to which a memorandum expressing the views of the Branch Council was presented.

Repatriation Department Local Medical Officers.—Following the failure of lengthy negotiations between the Federal Council and the Repatriation Commission for an increase in fees payable to local medical officers, the Federal Council recommended that holders of local medical officer appointments throughout Australia should resign. A special meeting of local medical officers was held in May, but it was obvious that although there was considerable dissatisfaction with the fees at present paid, most appointees were reluctant to do anything which would adversely affect ex-servicemen, and consequently the question of resignation was not pursued. However, the Federal Council is continuing its approach to the Department for increased fees.

Workers' Compensation Fees.—Growing dissatisfaction among members with the existing schedule of fees applicable to the treatment of injured workers led to the opening of negotiations with the underwriters for increases in the schedule, but those negotiations have not yet been completed.

Salaries of Municipal Medical Officers of Health.—In 1940, after discussion with the Commission of Public Health, a scale of salaries for medical officers of health was agreed upon and recommended to the municipal authorities. In many cases that scale was accepted, but it remained unchanged until this year. Following further conferences between the Commission, the Municipal Association of Victoria and representatives of the Branch Council, it was recommended to municipalities that the salaries of medical officers of health should be increased, and members holding those appointments were advised to apply to their employing councils for a 100% increase in remuneration. Reports received subsequently indicate that in the majority of cases increases in salaries were granted.

Medical Officers of Gaols.—A protest has been submitted to the State authorities in reference to the inadequacy of salaries of part-time medical officers appointed to Her Majesty's gaols in the country, with a further request that vacant

appointments be publicly advertised and not be a matter of private negotiation.

Post-Mortem Examinations.—Fees payable to doctors conducting post-mortem examinations and appearing as witnesses in the Coroner's Court have remained unchanged since 1948, but repeated requests for those fees to be increased by amendment to the *Coroner's Act* have been refused by the Attorney-General.

Medical Student Quota.—The Council was gravely concerned to learn that at very short notice the admission of students in 1957 to the pre-medical year had been restricted to 200. Strong representations on this matter were made to the University authorities, culminating in a conference with representatives of the Council of the University and the Faculty of Medicine. Reluctantly the Council had to accept the views of the University authorities that limitations of space and staff, and ultimately money, were the governing factors and it was impossible to avoid the imposition of a quota. It is hoped that the report of the Murray Commission will lead to increased Commonwealth grants to the universities of Australia and that the University of Melbourne will then be able to extend its facilities.

Deficiencies of the National Health Service.—After five years of operation, with during that period a steady decrease in the value of money, it has become obvious that the medical and hospital benefits available under the National Health Service are inadequate, and the Branch Council urged the Federal Council to make representations to the Prime Minister on the matter. Appropriate action is being taken, and it is hoped that additional Commonwealth subsidies will enable benefit organizations to grant medical and hospital rebates on a substantially higher level.

The Future of Medical Practice.—The Organization Subcommittee has held several meetings to consider matters in relation to the National Health Service and possible alterations in the form of medical practice which might result from political changes. In the near future members will receive a pamphlet referring to those possibilities, and, later, meetings will be held throughout Victoria to inform members more fully.

Information Service Subcommittee.—During the year a new subcommittee—the Information Service Subcommittee—was appointed with the object of improving relations with the Press and the public. The services of an experienced journalist have been retained as an adviser, and the value of this new arrangement has already become apparent.

Charging of Booking Fees.—A recommendation from a suburban subdivision that a booking fee should be charged for other than cash payments was considered by Council and rejected, the strongest opponents being the general practitioner members of Council.

Company Formation by Medical Practitioners.—This question has been the subject of discussion in State Branch Councils and the Federal Council during recent months, and all are unanimously of the opinion that only under the following conditions should companies associated with the conduct of medical practice be formed:

(1) Membership of the company shall be confined to medical practitioners actively engaged in medical practice.

(2) No member shall practise his profession as a member of a company or conduct his practice in association with such company unless the control of the company is at all times completely in the hands of registered medical practitioners.

(3) The governing director shall at all times be a registered medical practitioner.

A Legacy.—The late Wilfred Russell Grimwade, Kt., C.B.E., B.Sc., F.C.S., F.R.A.C.I., who had been elected a complimentary member of the Branch in appreciation of his benefactions to medicine, bequeathed in his will the sum of £1000 to the Medical Society of Victoria. A plaque in his memory has been erected in the foyer of the Medical Society Hall, and the bequest is being held in trust for a suitable memorial to be determined in the future.

Albert Street Properties.—It was decided to convert the properties at 384-386 Albert Street, East Melbourne, which the Medical Society of Victoria has owned for some years, into professional rooms, and they were officially opened by the Honourable the Minister of Health on November 28. To facilitate the control of these properties and adjacent properties in Lansdowne Street (which were purchased during the year), steps have been taken to form a "holding company" to act in trust for the Medical Society.

Car Parking.—Repeated representations have been made during the year to the City Council to obtain parking concessions for members, which have, in some instances, led to limited success.

Other Business.—Many other matters have been dealt with by both the Branch Council and the Executive in addition to the above. A great deal of business arising from the activities of the Federal Council has not been mentioned here, as full reports of the meetings of the Federal Council appear in THE MEDICAL JOURNAL OF AUSTRALIA.

Federal Council.

The Federal Council met twice during the year, in Sydney in February and in Adelaide at the end of August and the beginning of September. Full reports of the proceedings of the meetings have been published in the issues of THE MEDICAL JOURNAL OF AUSTRALIA of April 6 and October 5.

The Library of the Medical Society of Victoria.

Meetings of the Library Advisory Committee have been held regularly each month, when new books received on approval and suggestions submitted by members have been considered. A systematic clearing of older books from the shelves has also been undertaken, some of which have been accepted into the museum and others discarded or passed on to other libraries. Duplicate copies of journals and short series of discontinuel subscriptions have been passed on to the Central Medical Libraries Organization for exchange purposes.

Over one hundred new books have been added to the library during the past year as gifts, purchases or loan volumes from H. K. Lewis and Company.

New journals are: *The American Journal of Digestive Diseases, British Journal of Clinical Practice, Medical History, Weekly Abstract Library Bulletin.* The following have been discontinued: *Medical and Biological Illustrations,* "The British Encyclopædia of Medical Practice". Others are under review, as the committee considers the space occupied by little used journals could be used to better advantage.

Early in the year the more recent books were removed from the glass case and placed on open shelves with better spacing, and sections have been labelled in order that readers may see more readily what is available in different subjects. The alteration has proved very popular.

Borrowings during the year were approximately 2500, and it is pleasing that country members are making more use of the library facilities.

There are gaps in some journal holdings, due chiefly to borrowed numbers not being returned. An appeal has been made through the monthly paper and will be repeated. The committee would be grateful if members who have subscriptions to the journals mentioned would donate missing numbers.

In order to make way for the museum collection, books and journals housed in the museum room will be removed. Storage space for these is to be made available in "Mollison House" at 384 Albert Street. Books and journals belonging to the Physiotherapy Association have been removed, and a rearrangement of the library fixtures will now be possible.

The Committee desires to record thanks to the following donors for gifts to the library and museum, many of which are valuable additions: THE MEDICAL JOURNAL OF AUSTRALIA, *The Australian and New Zealand General Practitioner,* Ciba Limited, Dr. A. C. Bell, Dr. H. Boyd Graham, Dr. Lucy Bryce, Dr. B. Christophers, the Melbourne Radiological Clinic Partnership, Dr. Bryan Gandevia, Dr. Euan Littlejohn, Dr. Alan McCutcheon, Dr. E. McComas, the late Herman Jacks, Dr. G. Newman-Morris, Dr. George Simpson, Dr. Mary Thornton, Dr. Fred Williams, Saint Vincent's Hospital Library and the British Medical Insurance Company.

V. L. COLLINS,
Honorary Librarian.

Museum.

The past year has been notable for some changes in museum administration, the clarification of future policy and the definition of responsibility for certain books in the Library.

Early in 1957 a Museum Advisory Committee was formed, consisting of the Acting Honorary Curator, Dr. J. H. W. Birrell and Dr. M. L. Verso, with the Honorary Librarian as chairman. At the second meeting a lengthy memorandum setting out the policy and functions of the museum was adopted. Among other consequences of this report, it is to be expected that visible signs of museum activity and holdings will be made available to members in the form of regular exhibitions commencing early next year. Another sequel has been the establishment of permanent represen-

tation on the Library Committee and the Committee of the Section of the History of Medicine. The museum, on behalf of the library, will in future accept custody of all books more than about 100 years old and of all books published in Australia more than fifty years ago. These will in due course form two collections of considerable historical interest. The Australiana collection lacks a number of important items, but its completeness for the future is assured; firstly by the library's adoption of the collection of medical Australiana as one of its functions, and secondly by the courtesy of the Editor of THE MEDICAL JOURNAL OF AUSTRALIA, who has agreed to donate review copies of these works to the library.

An outline of the numerous tasks to be undertaken before the museum can be fully functional has been considered by both Museum and Library Committees, and the need for space and for some form of part-time assistance is under review.

Accessions include gifts from Mrs. W. H. Fitchett, Mrs. C. Stephen, Dr. G. Newman-Morris, Dr. E. Littlejohn, Brigadier R. W. Tovell and Dr. C. Macdonald, and these are gratefully acknowledged. Gifts of certain books have also been received through the library. The archives section has benefited from much material obtained through the activities of the Section of Medical History. The value of archives for research will be greatly enhanced through a recent arrangement with the archives department of the Public Library, whereby material in that department will be indexed in our files. The generous cooperation of the Public Library staff is very much appreciated.

As the Honorary Curator returned from abroad during the year, Dr. H. Boyd Graham relinquishes his duties as Acting Curator, but he has agreed to remain a member of the committee. It is fitting to record at this stage that all future developments in the museum will inevitably owe a great deal to Dr. Boyd Graham's foresight and patient work over many years.

This report may well conclude by quoting the final words of the memorandum previously referred to:

> There is no doubt that the Museum can be developed to depict in an interesting and informative manner the history of Victorian and indeed Australian medicine. There is also no doubt that there is an urgent need for such an institution. No organization in this country, as far as I am aware, systematically collects Australian medical books, preserves and indexes Australian medico-historical publications, and collects documents and medical apparatus of Australian interest. It is vital to further research in the history of Australian medicine that this work be undertaken, and for technical historical reasons it can perhaps best be undertaken in Victoria.

The assistance of members in furthering these aims is earnestly sought.

BRYAN GANDEVIA,
Honorary Curator.

Reports of Subdivisions.

Metropolitan.

South Central.—Office bearers: Branch Council representative, Dr. J. Gavin Johnson; Chairman, Dr. James Smibert; Honorary Secretary, Dr. L. W. Knight.

Two meetings of the Subdivision were held during the last twelve months. At the first, held on November 20, 1956, after the election of chairman and honorary secretary, the following subjects were discussed: the Pensioner Medical Service, public relations, concessional fees; the establishment of the Victoria Faculty of the College of General Practitioners. The second meeting was held on August 10, 1957, and preceded a dinner at the Hotel London. The subjects discussed at this meeting included the National Health Service, public relations and the cost of collection of fees.

LINDSEY W. KNIGHT,
Honorary Secretary.

Western.—Office bearers: Branch Council representative, Dr. N. L. Dodd; Chairman, Dr. N. L. Dodd; Honorary Secretary, Dr. Donald D. Coutts.

No meeting of the subdivision has been held during the past twelve months.

DONALD D. COUTTS,
Honorary Secretary.

Southern.—Office bearers: Branch Council representative, Dr. H. F. Tucker; Chairman, Dr. L. C. Brittingham; Honorary Secretary, Dr. A. O. Rosenhain.

One meeting of the subdivision was held during the year, on July 16, 1957, at which the office bearers were elected.

Dr. H. F. Tucker was nominated to represent the subdivision on the Branch Council, following the resignation of Dr. G. R. Weigall on his appointment as a trustee of the Medical Society of Victoria. A presentation of a silver salver was made to Dr. Weigall on behalf of the members as a token of their appreciation of his twenty-three years' service as representative of the subdivision on Council.

A. O. ROSENHAIN,
Honorary Secretary.

Eastern.—Office bearers: Branch Council representative, Dr. H. G. Judkins; Chairman, Dr. A. S. Ferguson; Honorary Secretary, Dr. H. J. Hosking.

One meeting was held during the year. Following the election of office bearers, Dr. Dickson spoke on several medico-political topics of current interest, including the Pensioner Medical Service. After some discussion the following resolutions were passed: (i) It is considered that the present fees paid to medical officers of the Pensioner Medical Service are inadequate. (ii) That as the Minister of Health has not honoured his agreement in regard to review of fees each six months, the British Medical Association is urged to lead members in the application of sanctions. (iii) In any future agreement with the British Medical Association in regard to fees there should be the right of appeal to an arbitrator. These motions have since been submitted to the Branch Council for consideration.

Dr. A. Griffiths concluded the meeting with a talk on the achievements and aims of the College of General Practitioners.

H. J. HOSKING,
Honorary Secretary.

Country.

Ballarat.—Office bearers: Branch Council representative, Dr. M. H. Robinson; Substitute representatives, Dr. N. F. Pescott and Dr. F. P. McArdle; Chairman, Dr. P. G. Smith; Vice-Chairman, Dr. J. S. T. Stevens; Treasurer, Dr. F. P. McArdle; Secretary, Dr. N. F. Pescott; Local Committee Members, Dr. M. Robinson, Dr. D. B. Skewes, Dr. D. A. Alexander, Dr. C. E. Richardson, Dr. R. Gough.

The annual meeting for 1956-1957 was held on September 27, 1956, in the form of a dinner at Craig's Hotel. The guest speaker was Dr. W. E. King, who gave a most interesting and entertaining after-dinner speech on his recent trip abroad.

The Olympic rowing and canoeing in Ballarat provided between 20 and 30 local and country practitioners with a special interest and extra work at a daily sick parade. A roster system for three sick parades per day for six weeks was drawn up and there was a surprisingly large attendance —at one stage reaching 10% of the athletes per day. The subdivision was most appreciative of the work done by the practitioners and the guidance and help from the Advisory Committee in Melbourne.

Four post-graduate lectures were held at approximately three-monthly intervals during the year. As usual they were all excellent lectures and well attended. The lecturers were Sir Macfarlane Burnet ("The Present State of Virus Disease"), Mr. Bryan Keon-Cohen ("Backache"), Dr. Keith Bowden ("Medico-Legal Problems"), Dr. Mostyn L. Powell ("Recent Adavnces in Pædiatrics").

The annual meeting for 1957 will be held on October 3. Sir Kingsley Norris has kindly consented to be the guest speaker.

NEIL F. PESCOTT,
Honorary Secretary.

Bendigo.—Office bearers: Branch Council representative, Dr. E. Sandner; Substitute representatives, Dr. W. T. C. Straede and Dr. M. Clark; Chairman, Dr. W. J. Long; Vice-Chairman, Dr. N. N. Harrington; Honorary Secretary, Dr. A. J. Walters; Honorary Treasurer, Dr. P. Kirby.

During the past year four post-graduate meetings were held on topical subjects, and interest was shown by the lively discussions which followed the informative lectures given.

Recorded lectures continue to be received by the subdivision from the Post-Graduate Committee, and valuable information is gained from this very much appreciated service.

Honorary service has been expanded at the Bendigo Hospital to conform with the plan to extend the base hospital services to cover the Loddon Valley region of Victoria.

A. J. WALTERS,
Honorary Secretary.

Gippsland.—Office bearers: Branch Council representative, Dr. D. F. Mitchell; Substitute representative, Dr. J. M.

Andrew; Chairman, Dr. J. M. Andrew; Honorary Secretary, Dr. John E. Joseph.

On October 6, 1956, the Victorian Branch of the British Medical Association held a Branch meeting at Sale. With Dr. Swinburne as Chairman, a series of cases were presented by Dr. Baldwin, Dr. Pollock and Dr. Fitzpatrick of Sale and Dr. Howson of Maffra. After dinner at the Criterion Hotel, Dr. Jenkins of Maffra read an original paper on "The Clinical Signs of Nervous Disease".

On November 20, 1956, a well attended meeting was held at the Latrobe Valley Community Hospital, Yallourn. Professor Andrew M. Claye, Sims Black Travelling Professor in Obstetrics and Gynæcology, gave a lecture entitled "Threatened and Habitual Abortion". During their stay at Yallourn, Professor and Mrs. Claye were taken on a conducted tour of the State Electricity Commission's works at Yallourn.

On April 6 and 7, 1957, the Post-Graduate Committee held a series of four lectures given by Dr. J. Hurley, Dr. B. Robinson, Dr. G. Ley and Mr. J. C. McNeur. This series was conducted at the Traralgon and District Hospital.

On August 17, 1957, a clinical meeting was held at the Gippsland Base Hospital, Sale, under the auspices of the Royal Australasian College of Physicians. During the afternoon clinical cases were presented by Dr. P. Parsons, Dr. J. Frew and Dr. K. Grice. In the evening, with Dr. W. E. King as chairman and a panel consisting of Dr. Frew, Dr. Grice, Dr. Parsons and Dr. Cade, a quiz session was conducted, and it was most entertaining.

JOHN E. JOSEPH,
Honorary Secretary.

South Western.—Office bearers: Branch Council representative, Dr. W. R. Angus; Substitute representatives, Dr. L. T. Griffiths and Dr. B. S. Alderson; Chairman, Dr. W. R. Angus; Vice-Chairmen, Dr. B. D. Vaughan and Dr. J. K. Gardner; Honorary Secretary, Dr. R. R. Sobey; Committee, Dr. S. Fitzpatrick, Dr. H. C. Maling, Dr. C. B. Berryman, Dr. R. McDougall and Dr. W. M. Davies.

Four subdivisional meetings have been held in the past twelve months. These were at Warrnambool, Camperdown and Colac. As previously, the meetings took the form of combined business, medical and social gatherings. Social and general British Medical Association business was discussed. The medical sections were arranged in conjunction with the Melbourne Medical Post-Graduate Committee, which supplied lecturers. The average attendance at the meetings was 15. In addition, the March Branch meeting of the Association was held at Hamilton, during which a most interesting series of clinical cases was presented and discussed.

R. R. SOBEY,
Honorary Secretary.

North Western.—Office bearers: Branch Council representative, Dr. B. Hutton Jones; Substitute representatives, Dr. A. Hinchley and Dr. Ross Webster; Chairman, Dr. G. Forsyth; Honorary Secretary, Dr. Ross Webster.

Two post-graduate meetings have been held this year, at Warracknabeal and Mildura, and a third will be conducted in Horsham in November. The meetings continue to be well attended and the subdivision wishes to record its thanks to the Post-Graduate Committee.

ROSS WEBSTER,
Honorary Secretary.

Goulburn.—Office bearers: Branch Council representative, Dr. D. F. Lally; Substitute representatives, Dr. F. V. Harder and Dr. F. R. Cawthorn; Chairman, Dr. A. E. Dickmann; Honorary Secretary, Dr. Brian Schloeffel; Honorary Treasurer, Dr. A. F. Taylor.

Two lecture series were held this year by the Melbourne Medical Post-Graduate Committee. These were, as usual, highly successful, both from the academic and social point of view.

The first lectures were on November 17, 1956, and were run in conjunction with a special garden fete conducted by Mooroopna Base Hospital. The attendance of 30 medical practitioners was the largest recorded here for such an occasion over the last 11 years. The speakers were Mr. Eric Price, whose subject was "Fractures and Joint Injuries", and Dr. Kaye Scott, who spoke on "The Reticuloses".

An almost identical audience foregathered on March 16, 1957, to hear Dr. Donald Lawson speak on "Ante-Natal and Post-Natal Care", and Mr. Russell Howard on "Congenital Abnormalities".

On each occasion the lectures were followed by a buffet dinner held at "Mandelay" in Shepparton. Entertainment was provided in private homes for wives of the visitors.

It has been found that confining the lectures to one day of a week-end only, and the delivery of these before the evening meal, has resulted in a larger and more attentive average audience.

On each occasion, with the consent of the Post-Graduate Committee and the participating lecturers, a tape recording of the lectures has been made.

BRIAN SCHLOEFFEL,
Honorary Secretary.

Geelong.—Office bearers: Branch Council representative, Dr. D. A. Carter; Substitute representative, Dr. D. A. Kidd; Chairman, Dr. D. A. Seward; Vice-Chairmen, Dr. W. Morris and Dr. E. Fargie; Honorary Treasurer: Dr. M. S. Benson; Honorary Secretary, Dr. V. D. Plueckhahn.

Five business meetings were held during the year, and the average attendance was 24. In addition six meetings of the committee were held.

The following clinical meetings were held: (*a*) On October 20, 1956, a full day's clinical meeting, followed by a dinner in the evening. Over 60 members attended. The guest speakers were Professor Lovell, who spoke on "Cortisone", and Professor Ewing, who spoke on his impressions of Australia. The local speakers were Mr. C. Gale ("Urethral Stricture"), Dr. J. Agar ("Acute Infective Hepatitis"), Dr. J. Bishop ("Corneal Graft"), Mr. K. Coleman ("Subacute Swelling in the Right Iliac Fossa"), and Dr. V. Plueckhahn ("Malignant Melanomata"). (*b*) On the evening of April 17, 1957, a second clinical meeting took place. The guest speaker, Dr. Glyn White, spoke on "Some Aspects of Neo-natal Morbidity". Forty-two local members attended.

A combined meeting with the Geelong Law Association was held in June, 1957, when Dr. N. McCallum spoke on "The Drunken Driver and Blood Alcohol Tests".

The annual dinner dance (the ladies' night) was held on September 21, 1957. It was attended, and thoroughly enjoyed, by 130 members, wives and friends.

V. D. PLUECKHAHN,
Honorary Secretary.

Reports of Sections.

Australian Otolaryngological Society (Victorian Division).—Office bearers: Chairman, Dr. John Shaw; Vice-Chairman, Dr. R. S. Stevens; Committeeman, Dr. H. Watson; Treasurer, Dr. R. C. Willis; Secretary, Dr. David Cossar.

The annual general meeting of the division was held in March, when the above office bearers were elected.

During the year well attended clinical meetings were held at the Royal Children's Hospital and at the Alfred Hospital.

In June, Mr. C. P. Wilson, C.V.O., F.R.C.S., Ear, Nose and Throat Surgeon to the Middlesex Hospital, visited Melbourne. During his stay he delivered a series of lectures and commented on cases, both at teaching hospitals and at a special clinical meeting.

In August the annual general meeting of the Australian Otolaryngological Society was held in Melbourne, and the elected Executive comprised: President, Dr. John Shaw; Vice-President, Dr. R. C. Willis; Treasurer, Dr. C. S. Richards; Secretary, Dr. David Cossar.

A successful scientific programme was held, and, also, members were invited to attend functions arranged by the Royal Australasian College of Surgeons in connexion with the annual meeting of the College which was held during the same week.

D. F. COSSAR,
Honorary Secretary.

Ophthalmological Society of Australia, Victorian Section.—Office bearers: Chairman, Dr. R. Lowe; Honorary Treasurer, Dr. P. Cowen; Honorary Secretary, Dr. J. Murphy.

Six meetings of the Victorian Section of the Ophthalmological Society of Australia were held during the past year.

The main items of business concerned the recommendation to the Director of Social Services that blind claimants should be referred to a member of the Ophthalmological Society of Australia wherever possible; the appointment of a consultant ophthalmologist to the Schools Medical Service; and the organization of the forthcoming annual general congress to be held in Melbourne.

During the year Professor Francois, of Ghent, was entertained at a dinner and addressed the meeting on "Electro-oculography as a Functional Test".

At other meetings the following members spoke on recent overseas experiences: Dr. R. F. Lowe, Dr. J. McBride White, Dr. R. Collmann and Dr. J. Ringland Anderson.

Dr. Wilson and Dr. French, of the Public Health Laboratory, University of Melbourne, spoke on "The Role of Serological Tests in Ophthalmology, Particularly in Regard to Toxoplasmosis and Brucellosis".

Mr. Power, of the Royal Melbourne Technical College, demonstrated his projection reader.

Dr. Greer, of the pathology department, Eye and Ear Hospital, commenced a series of short talks on subjects of clinical interest.

JUSTIN E. MURPHY,
Honorary Secretary.

Section of Clinical Pathology.—Office bearers: Chairman, Dr. A. Williams; Honorary Treasurer, Dr. G. G. Harkness; Honorary Secretary, Dr. D. C. Forster; Committee, Dr. R. A. Barter, Dr. S. O. M. Were.

During the year regular meetings were held, at which the following papers were presented:

Dr. A. Williams, "Pneumonia Due to Pneumocystis Carnii".

Dr. Michael Wilson, "Typhoid Fever in Victoria".

Dr. L. Taft, "Tubular Necrosis".

Dr. E. Storey, "Some Studies on the Relaxation of Collagen During Pregnancy".

Dr. John Forbes, "ECHO Virus Meningitis in Melbourne—Clinical Aspects".

Dr. A. Ferris, "ECHO Virus Meningitis in Melbourne—Laboratory Aspects".

Dr. T. R. Lubbe, "An Unusual Ureteric and Pelvic Tumour".

Dr. M. Verso, "A Case of Anti-S Agglutinin".

Dr. C. Pringle, "Cholinesterases in the Heart and Their Functional Significance".

DONALD C. FORSTER,
Honorary Secretary.

Section for the Study of Allergic Diseases.—Office bearers: Chairman, Dr. Gerald Doyle; Immediate Past Chairman, Dr. Ivan Maxwell; Secretary-Treasurer, Dr. Alan Murray; Executive Committee, Dr. R. H. O. Donald and Dr. D. A. Prentice.

There are 20 members in the section and the average attendance at meetings was 15. Four meetings were held during the year.

The meeting in November, 1956, took the form of a Branch meeting, when the section arranged a symposium on "Bronchitis, Asthma and Emphysema in Childhood". Dr. Ivan Maxwell outlined treatment, and Dr. R. H. O. Donald opened the discussion.

In March, 1957, Professor F. H. Shaw, of the Department of Pharmacology, University of Melbourne, read a paper entitled "The Allergic Reactions of Morphine".

The May meeting took the form of a discussion on "The Prescribing of Cortisone as a Pharmaceutical Benefit in Status Asthmaticus", and Dr. H. M. Franklands, Commonwealth Director of Health, addressed the meeting.

Dr. Gerald Doyle read a paper in August entitled "A New Conception of Asthma".

ALAN MURRAY,
Honorary Secretary.

Section of Radiology.—Office bearers: President, Dr. A. G. Mackay; Secretary, Dr. D. Lloyd Dick.

Monthly scientific meetings were held throughout the year, and visiting radiologists, Dr. Merrill Sosman, from Boston, U.S.A., Dr. Whately Davidson, from Newcastle, England, and Dr. J. F. Bromley, also from England, addressed the section during their visits to Melbourne. During the year negotiations with the Hospitals and Charities Commission concerning the employment of radiologists in public hospitals were continued through the Special Committee of the Council of the Victorian Branch and finality reached.

D. LLOYD DICK,
Honorary Secretary.

Section of Industrial Medicine.—Office bearers: President, Mr. Douglas Donald; Secretary, Dr. W. F. Cooper; Treasurer, Dr. R. D. Wilson; Committee, Dr. S. Crawcour (who resigned during the year and was replaced by Dr. John Gowland), Dr. A. Christophers, Dr. Leigh Wedlick, Dr. Leo Gurry and Mr. Ferguson Laidlaw.

The section conducted the following activities during the year:

A weekend conference at the Hotel Manyung from March 1 to 3, 1957. Subjects at the conference were: "Future Training in Industrial Medicine", by Dr. R. D. Wilson; "The Scope of Industrial Medicine", by Dr. W. F. Cooper; "Medical Legislation in Victoria", by Dr. Allen Christophers.

A plant walk at Anodeon Electronics Park on May 21, 1957, with a demonstration by the Public Health Department on "Atmospheric Carbon Monoxide Estimation".

On October 4, a combined meeting was held with the Section of Otolaryngology. The guest speaker was Dr. Hugh A. Kuhn, who spoke on "Acoustic Trauma".

On November 13, a combined meeting with the Branch was held at a symposium on "The General Practitioner in Relation to Industry".

Medical students, Division 3, Fourth Year, who are competing for the Edgar Rouse Prize of 1957, were given facilities for industrial visits in connexion with the subject chosen for the prize, "Occupational Factors in the Ætiology of Diseases".

W. F. COOPER,
Honorary Secretary.

Australian Rheumatism Association (B.M.A.), Victorian Section.—Office bearers: Chairman, Dr. Frank May; Honorary Secretary, Dr. Roderick Strang; Honorary Treasurer, Dr. Michael Kelly.

The Federal Council of the British Medical Association gave approval in December, 1956, for the formation of the Australian Rheumatism Association, and subsequently in June, 1957, the Branch Council approved of the formation of the Victorian Section.

The first official meeting of the section was held on September 17, 1957, when the office bearers were elected. As the section is in the formative stage, there are as yet no activities to report.

RODERICK STRANG,
Honorary Secretary.

Section of Medical History.—Office bearers: President, Dr. Colin Macdonald; Honorary Secretary, Dr. M. L. Verso; Honorary Treasurer, Dr. J. H. Birrell.

Since the last report was issued, the following meetings have been held:

December 3, 1956: A Members' Night, when a number of short papers was read and exhibits shown by several members of the Section.

March 4, 1957; Dr. Keith Bowden read a paper on "S. T. Gill, the Artist of the Goldfields".

July 1, 1957: Dr. W. G. D. Upjohn read a paper on "Hamilton Russell".

October 7, 1957: Dr. W. W. S. Johnston read a paper on "A Testimonial to Dr. Aubrey Bowen", and Dr. Bryan Gandevia showed lantern slides of medico-historical interest.

The annual dinner was held on August 9, and proved highly successful. The guest of honour was Professor R. J. Kellar, Professor of Obstetrics and Gynæcology in the University of Edinburgh, who spoke on his predecessors in that chair.

In addition to the papers read at meetings, a number of papers on medico-historical subjects has been published by members during the year.

M. L. VERSO,
Honorary Secretary.

On behalf of the Branch Council,

ALAN B. MCCUTCHEON, President.
G. NEWAN-MORRIS, Honorary Secretary.
C. H. DICKSON, Medical Secretary.

This report would not be complete without reference to the invaluable assistance rendered by Dr. Dickson to the Branch throughout the year. He has been most helpful to me personally, and it has always been a pleasure to discuss matters with him. Our thanks go also to Miss Corley and the staff for the willing way in which they carry on what is a steadily increasing volume of business and do it with a smile.

ALAN MCCUTCHEON,
President.

Addendum.

The following reports are published on behalf of the Melbourne Medical Postgraduate Committee.

In the past year, the membership of the committee was increased by the appointment of a representative of the newly formed Victoria Faculty of the College of General Practitioners. The committee now comprises representatives

of the Faculty of Medicine, the British Medical Association, the teaching hospitals in the Melbourne Medical School, the State Committee of The Royal Australasian College of Physicians, the Regional Council of the Royal College of Obstetricians and Gynæcologists, the State Health Department, the Repatriation Department and some coopted members. The members of the committee hold office for one year, but are eligible for nomination for further terms.

The committee, through the Chancellor of the University of Melbourne, submitted a report on its activities for consideration by the Committee on Australian Universities. The approach made to the State Government for an increase in the annual grant to offset administrative costs was not successful. The committee seeks the full support of the profession as a whole and urges doctors to become annual subscribers. Four hundred and seventy-five annual subscribers enrolled for 1957, a slight increase when compared with last year's figures.

Mr. Anthony R. Kelly succeeded Major-General Sir Kingsley Norris as Honorary Secretary of the committee. The latter was appointed an Emeritus Councillor in recognition of his services to the committee. Dr. H. N. B. Wettenhall was appointed the representative of the Royal Children's Hospital in place of Dr. M. L. Powell, who retired after serving in that capacity for ten years.

The committee again provided the executive for the Australian Post-graduate Federation in Medicine, a function to be taken over by the Adelaide Post-graduate Committee from October, 1957.

Courses Suitable for Candidates for Post-graduate Qualifications.—In conjunction with the appropriate departments in the University of Melbourne, the committee again arranged courses in the basic sciences. The course in radiodiagnosis was conducted in conjunction with the College of Radiologists. The Australian Association of Psychiatrists and the Victorian Section of the Ophthalmological Society of Australia (British Medical Association) conducted courses for diploma candidates. The honorary staff at the Alfred Hospital conducted a course in medicine, which 16 doctors attended, and the honorary staff of St. Vincent's Hospital conducted a course in surgery, which was attended by six doctors.

Overseas Lecturers.—The following overseas visitors gave lectures for the Committee: Dr. A. Ashley Weech, Professor of Pædiatrics, Cincinnati, U.S.A.; Dr. Merrill C. Sosman, Professor of Radiology, Boston, U.S.A.; Dr. Whately Davidson, F.F.R., and Dr. John Bromley, F.F.R., both of London; Mr. C. P. Wilson, Ear, Nose and Throat Surgeon, of Middlesex Hospital, London; Professor R. J. Kellar, Professor of Obstetrics and Gynæcology, Edinburgh, the Category A Lecturer for 1957 of the Australian Post-graduate Federation in Medicine; Professor Robert Cruickshank, Principal of the Wright-Fleming Institute of St. Mary's Hospital, London; Dr. Daniel Morton, Professor of Obstetrics and Gynæcology, U.C.L.A. Medical Centre, Los Angeles. In addition the committee has arranged for three further lecturers in October and December, 1957: Sir Russell Brock, M.S., F.R.C.S., of Guy's Hospital, London; Sir Geoffrey Jefferson, C.B.E., F.R.S., M.S., F.R.C.S., F.R.C.P., Director of the Neurological Laboratories, University of Manchester; Dr. Owen H. Wangsteen, Professor of Surgery, University of Minnesota Hospital.

Recorded Lectures.—The following lectures were recorded during 1957 and transferred to microgroove disks. These are available for distribution, together with illustrating slides, to groups of listeners or individuals, particularly those in the country. Arrangements were also made to provide the post-graduate committees in Sydney, Adelaide, Brisbane and New Zealand with copies of a number of these recordings. The lectures recorded were: "Leukæmia", by Professor L. J. Witts; "Persistent Periodic Non-infantile Afebrile Colic", by Dr. Ashley Weech; "The Accuracy and Reliability of the Roentgen Examination", by Dr. Merrill Sosman; "Pregnancy Toxæmia", by Professor Robert Kellar; "Carcinoma of the Cervix", by Professor Robert Kellar; "Ante-partum Hæmorrhage", by Professor Robert Kellar; "The Endocrine Control of the Menstrual Cycle in Health and Disease", by Professor Robert Kellar; "The Rational Use of Antimicrobial Drugs", by Professor Robert Cruickshank; "Varicose Veins and Ulcers", by Mr. A. Dickson Wright, surgeon, of St. Mary's Hospital, London; "Principles in the Differential Diagnosis of Lung Disease", by Sir Russell Brock.

Metropolitan Refresher Courses.—Refresher courses for general practitioners in medicine and surgery and also in obstetrics and gynæcology were held during the year, and the numbers attending were, respectively, 14 and 13. A refresher course in obstetrics and gynæcology suitable for recent graduates was also held, but the corresponding course in pædiatrics was omitted because of the Jubilee Post-graduate Week conducted by the Pædiatric Society of Victoria.

Country Courses.—Nineteen country courses were arranged for 1957, in which 42 lectures were given. These included for the first time a number of short presentations of academic and research work. The lesser number of attendances recorded is due mainly to delays in reports of meetings.

Post-graduate Training of Overseas and Interstate Graduates.—In 1957, the committee arranged post-graduate training for 22 overseas and interstate graduates. At the request of the Department of External Affairs, arrangements were made for post-graduate work by two World Health Organization Fellows from Thailand. Other overseas graduates came from New Zealand (four), India (one), Singapore (one) and, under the ægis of the Colombo Plan, two graduates came from the Philippines, and were given some assistance by this committee.

Through the Australian Post-graduate Federation in Medicine and the Department of External Affairs, the committee arranged for an anæsthetist to take up an appointment in Singapore for a term of one year to assist in clinical work and teaching at the Singapore General Hospital.

General.—The committee has continued to arrange for the overseas training of doctors proceeding to the United Kingdom and the United States of America and, in 1957, arrangements were made for 36 graduates. Individual courses of instruction and clinical work in teaching hospitals in Melbourne were also made for a number of graduates.

The following figures indicate the number of doctors who have availed themselves of the facilities offered by the committee in 1957, up to September 30:

Total number of enrolments for courses and clinics	554
Numbers attending courses for higher qualifications	152
Numbers attending country courses (on reports received)	133
Numbers attending metropolitan refresher courses	28
Number of individual doctors who have attended one or more courses by overseas lecturers	284
Number of doctors for whom the committee has arranged training overseas	36

Acknowledgements.—The committee thank the 126 lecturers who took part in their courses during the year. They also express thanks to the deans and members of the clinical schools of the teaching hospitals and the members of the departments of the University of Melbourne for their assistance in carrying out the programme in 1957. The committee also acknowledges the financial assistance which Nicholas Proprietary, Limited, continue to give in the recording of lectures.

The British Medical Agency of Victoria Proprietary, Limited.

The year completed was not as successful as the record year of 1956, and the falling off of business was attributed to a certain timidity on the part of buyers and the difficulty of obtaining credit.

Many vendors of general practices tried to overcome the credit problem by offering most inviting terms, but these were often refused when the purchaser found credit restricted elsewhere. Country practices were no easier to sell, despite very attractive conditions.

The valuation of houses connected with city practices is frequently such, that when added to the price of goodwill, the total figure is very substantial. There are, for example, some houses and practices in the metropolitan area priced as follows: house £12,000, practice (income £5000) £3000, total £15,000; house £11,500, practice (income £6000) £4000, total £15,500; house £18,000, practice (income £4500) £3000, total £21,000.

Although in May the locum shortage seemed solved, the influenza epidemic made it more acute than ever. The only response to an urgent advertised appeal for locums was from exhausted general practitioners asking if the advertisement was successful and could they be given relief. The most unusual case occurred when a member who had leased his practice was persuaded to do a fortnight's locum for his own lessee.

The death of Sir John Newman-Morris was recorded with very great regret, as he had always been interested and gave much help to the Agency.

The Directors are Dr. C. H. Dicksón (Chairman), Major-General Sir Kingsley Norris, Dr. Leonard Ball and Dr. Robert Southby.

The British Medical Insurance Company of Victoria, Limited.

The annual report of the company was submitted, over the signature of the chairman (Sir Victor Hurley), at the ordinary general meeting on August 5, 1957. The following is a summary of the Report:

The Directors have pleasure in submitting for your approval the balance sheet, profit and loss account and appropriation account for the twelve months ended April 30, 1957.

The results of the year's operations (as disclosed in the Profit and Loss Account) have not, in the opinion of the Directors, been materially affected by any items of an abnormal character. The total premiums written for the year were £105,994, as compared with £85,612 last year. Net profit for the year was £10,007/11/1 after providing £5,950 for taxation. The appropriation account shows that £633 was allocated during the year to various institutions connected with the medical profession.

Up to date the company has given books to the value of £2945 and £13,697 in cash to the Medical Society of Victoria, and more than £4330 to various sub-branches of the British Medical Association and other institutions connected with the medical profession. It has also taken up debentures of the Medical Society to the value of £3000, upon which it is accepting interest at the rate of only 1% *per annum*, which, of course, saves the Medical Society a considerable sum in interest.

The Company has made the following loans to the Medical Society of Victoria: £3150 to finance a building purchase; £3000 to finance the purhase of an estate agency.

The Directors feel that members of the British Medical Association will be interested to know of the benefits that they received through the activities of the company, and feel sure that the knowledge will strengthen the already solid support given by the profession.

PRESENTATION OF GOLF TROPHIES.

The President announced the results of the golf tournament, and presented the trophies to the winners. The Gerald Weigall Championship Cup, Dr. J. R. Searls; the David Roseby Handicap Cup, Dr. G. Warming; spoons for the best in-round, Dr. G. P. Ryan, Dr. J. A. McLean; spoon for the best out-round, Dr. L. Rosengarten.

INSTALLATION OF THE PRESIDENT FOR THE ENSUING YEAR.

The chair was vacated by Dr. Alan McCutcheon, who installed Dr. Keith Hallam as President for the ensuing year. Dr. Hallam thanked the members for his election.

PRESIDENT'S ADDRESS.

Dr. Alan McCutcheon then read the retiring President's address (see page 273). The President, Dr. Keith Hallam, thanked Dr. McCutcheon for his address.

APPOINTMENT OF AUDITORS.

Messrs. J. V. M. Wood and Company were appointed auditors for the ensuing twelve months.

VICTORIAN BRANCH: SCIENTIFIC.

A MEETING of the Victorian Branch of the British Medical Association was held on September 4, 1957, at the Medical Society Hall, 426 Albert Street, East Melbourne.

Odd Skin Tumours.

PROFESSOR MAURICE EWING read a paper entitled "Odd Skin Tumours" (see page 283).

DR. ARTHUR DAY said that the more one saw of many skin conditions, the less one knew of their origin and diagnosis. Professor Ewing had not mentioned tertiary syphilitic tumours; not many were seen now, but in days gone by they were common and often difficult to diagnose. The acanthoma tumours were often misdiagnosed as squamous carcinoma.

DR. RUSSELL LANGLEY stressed the importance of rapid growth in the diagnosis of acanthomata, and said that he had found the examination of tissue smears useful in diagnosis. In smears from kerato-acanthomata few cells were found, but a smear from a squamous cell carcinoma showed many cells. He suggested that it was possible that kerato-acanthomata might be explained as squamous-celled carcinomata which had spontaneously healed. He considered that the medico-legal consequences of misdiagnosis in those two conditions might be important.

DR. D. PEARCE said that in recent years he had seen many kerato-acanthomata. In the past, most radiotherapists and dermatologists had treated them with heavy doses of X rays, but now a much smaller dose was used with good response. He had seen glomus tumours causing ridging of the nail bed.

DR. E. A. C. FARRAN asked whether glomus tumours would respond to coagulation by diathermy.

DR. E. E. DUNLOP said that glomus tumours were often difficult to find. In one case he had excised the pad of a finger, and the pathologist reported multiple sites of glomus tissue with no definite tumour.

DR. J. F. FUNDER said that the last three patients with "sebaceous cysts" referred from Prince Henry's Hospital had, respectively, a calcified epithelioma, a glomus tumour and a sebaceous cyst. He was surprised to hear that painless glomus tumours were rare, and he considered that many were confused with leiomyoma.

Professor Ewing, in reply, said that recently he had upset his students by regretting the disappearance of syphilis, which, in relation to clinical problems, was an exciting disease. The suggestion that smears should be taken interested him, and he would try that procedure. He could not answer the suggestion that there might be a relationship between molluscum and squamous-celled carcinoma, one being a stage of the other with healing or regression. He was, however, dismayed at the suggestion of medico-legal implications. In reply to Dr. Farran, Professor Ewing said that he would hate to coagulate glomus tumours, because they were so fascinating histologically and so nice to enucleate. He had had no experience of mass excision mentioned by Dr. Dunlop. Leiomyoma was, of course, a painful subcutaneous tumour, and he wondered whether it was possibly glomus in origin.

Out of the Past.

In this column will be published from time to time extracts, taken from medical journals, newspapers, official and historical records, diaries and so on, dealing with events connected with the early medical history of Australia.

RABBIT EXTERMINATION.[1]

[From the *Australasian Medical Gazette*, November, 1887.]

A MEETING of gentlemen interested in pastoral pursuits was held at Goldsbrough's wool stores Melbourne on October 31 to hear Professor Watson of the Adelaide University explain his method for the extermination of rabbits by inoculating them with what is known as rabbit scab. It was alleged that the disease in question was very deadly to rabbits and that no other animals could be affected with it. The meeting was of opinion that experiments should be made with a view to testing the efficacy of the method in question under natural conditions and that a piece of land should be enclosed for the purpose. Ultimately it was resolved that funds should be subscribed by those who were interested in the success of the experiments and that the Government should be asked for permission to introduce the scab under the most stringent precautions. On November 2, a deputation waited on the Premier with this object, and to obtain an understanding that the promotors of the scheme should not be held liable for any injury that may ensue from bringing a new disease to the colony.

[1] From the original in the Mitchell Library, Sydney.

Correspondence.

CHRISTIAN MEDICAL FELLOWSHIP CONGRESS MEETING.

SIR: Coinciding with the British Medical Association Congress in Hobart, the triennial meeting of the Christian Medical Fellowship will take place at Bishopscourt at the kind invitation of the Bishop of Tasmania, who is an honorary member of Congress. It will be followed by afternoon tea.

All members of Congress who are interested, and their wives, are cordially invited to the meeting at 2.30 p.m. on Monday, March 4.

The subject will be "Possibilities and Problems in Increased Cooperation between Doctors and Clergy". Speakers: Dr. Bruce Peterson, of Sydney; the Reverend Godfrey Kircher, until recently chaplain of the Royal Melbourne Hospital. The discussion will be opened by Dr. Gavin Johnson and Dr. Robert Southby, and we hope that there will be a free exchange of ideas on a difficult but important subject, which has in recent years exercised the minds of medical men in all parts of the Commonwealth.

Yours, etc.,

A. MURRAY CLARKE.

12 Collins Street,
Melbourne,
February 16, 1958.

"THE ISLAND CAMPAIGNS."

SIR: I wish to draw the attention of your readers to certain unfortunate and important omissions in the recently published medical volume of the war, "The Island Campaigns". These omissions appear to be due to the loss of material and the natural lack of medical knowledge and over-all appreciation of the medical situation obtaining at the time by the Official War Historian, who had to complete the final editing of this volume through unforeseen circumstances. The main omission is particularly unfortunate because the Official War Historian is unwilling to print a small addendum for distribution to the known receivers of this volume, or to include it in a volume still to be published. Consequently a very real, although unintentional, disservice, which could be greatly mitigated by inclusion of such an addendum, will be performed in the giving of such a wrong medical impression to those who read Volume III of the medical history of the war, "The Island Campaigns", without reading Volume I, "Clinical Problems of War", in which some inaccuracies also occur. It is the purpose of this letter, as far as possible, to attempt to mitigate this disservice as well as to correct the inaccuracies mentioned.

The following is the addendum which the writer requested, unsuccessfully, to have published.

Addendum or Supplement.

The impression must be gained from Volume III, "The Island Campaigns", that malaria was the cause of greater loss or wastage of manpower than diseases of the skin, because malaria in New Guinea (as in "Clinical Problems of War", Volume I) is again dealt with at length while diseases of the skin are barely mentioned. In order to keep the relative importance of diseases of the skin and malaria as causes of manpower wastage in their proper perspective, the reader is referred to Chapter 55, page 619, in the "Clinical Problems of War" (Volume I). Here it will be seen that, for a long period, diseases of the skin were a greater cause of manpower wastage than any other condition including malaria.

This should have been stressed, or at least emphasized, to preserve a correct over-all concept, and not omitted. The importance of diseases of the skin is indicated, although very briefly, on pages 152, 159, 328-329, 393 and others in "The Island Campaigns", both during and after the New Guinea episode. Also, the 2/5 Australian General Hospital, which not only initiated proper management and facilities for treatment of diseases of the skin, but also cared for more personnel with these conditions than any other medical unit in New Guinea, both as in-patients and out-patients, was not even mentioned in the section dealing with New Guinea. This, again, gives a very incorrect impression of how or by whom diseases of the skin were managed in the New Guinea area.

Further factors of significance which were accidentally omitted or incorrectly stated in Volume I ("Clinical Problems of War") include:

1. Towards the end of the New Guinea Campaign an instruction was issued from New Guinea Force Headquarters that the use of ointments generally and in particular for mycotic infections should be curtailed in favour of lotions. This was found to be necessary because ointments tended to aggravate most dermatoses in the hot, humid climate of New Guinea.

2. The brigading of E.P.I.P. tents side to side instead of end to end (first performed at the 2/5 Australian General Hospital) created wards which were considerably more airy and better ventilated, thus being more suitable for skin conditions particularly, as well as all others in the New Guinea climate.

3. On page 636, paragraph one, is seen the statement: "It has been suggested that in addition to the overaction of sweat and sebaceous glands, the drinking of chlorinated water may have caused irritation by excretion." This suggestion has received further support since that time by the fact that a higher incidence of acne has been found to exist in many cities in the United States of America, where all drinking water is chlorinated (*vide* "Acne Vulgaris: Its Ætiology and Treatment", *Australian J. Dermat.*, 1951, 1: 85), and also by the findings of E. Murray-Will (in the following discussion) that bathing in chlorinated water can also aggravate *acne vulgaris*.

4. In Volume I ("Clinical Problems of War"), page 638, paragraphs eight and nine, it was stated that "phyto-photodermatitis due to parsnips was also proved to occur in susceptible men". This was not the case, as can be seen in "Parsnip Dermatitis in the Tropics Under Active Service Conditions", *Australian J. Dermat.*, 1952, 1: 183, where it was shown that the condition was a traumatic, not an allergic one, and could be produced in anyone. In lines 14 and 15 of the same paragraph on page 638, the fact that "water was dripped at 15 minute intervals onto areas of skin on which parsnip scrapings were lying on volunteers" was omitted. If this dripping of water had not been performed, no reaction would have occurred. In addition, in line 18, the mention of exposure to solar radiation "soon after contact" should read "during contact".

Comment.

While I realize that the omissions and inaccuracies referred to were brought about by unforeseen circumstances, I feel, nevertheless, that the Official War Historian should make some effort to correct the mistakes which have occurred, in order both to keep the record correct and for the benefit of future readers. It is to be hoped that he may still see his way clear to do this, particularly since much other material supplied by the writer to the Medical War Historian, at his personal request, has also been omitted (again through unforeseen circumstances).

Yours, etc.,

J. C. BELISARIO,
Lecturer in Dermatology to the University of Sydney.

"Harley",
143 Macquarie Street,
Sydney.
February 6, 1958.

A STUDY OF THE COURSE OF PULMONARY TUBERCULOSIS AFTER TREATMENT WITH THORACOPLASTY.

SIR: In the review of Alexander Tuxen's "Study of the Course of Pulmonary Tuberculosis After Treatment with Thoracoplasty" there are several remarks that call for comment. The reviewer says that "many surgeons in Australia would regard a study of thoracoplasty as almost of historical interest". If the implication is that it is now of no practical interest, then I assert emphatically that there are many surgeons in Australia and abroad who disagree. As if he were in some doubt about his opinion, he goes on to say: "However, the operation still has a place, and has a very low operative mortality and morbidity. The Norwegian cases . . . are remarkable for the good results obtained. . . ." Later, he says: "Also, as the results of any operation bear some relation at least to the operative technique, it might have been reasonable to indicate in more detail the essential points of difference between the operation used in this series and operation commonly associated with the name of

Alexander." All thoracic surgeons honour John Alexander; they are also familiar with Carl Semb's technique for thoracoplasty. The author rightly supposed that the people for whom his book is intended would not expect unnecessary space to be taken in repeating what is already familiar to them. Finally, it is the essence of bad criticism to blame an author for omitting something which does not come within the scope of his book. The title shows that it is dealing with the results of thoracoplasty, not with the technique of the operation.

Yours, etc.,

185 Macquarie Street, Sydney, January 18, 1958.

M. P. SUSMAN.

[The reviewer to whom Dr. Susman's letter was referred for comment states that a few years ago opinions were collected and consolidated from nearly all the thoracic surgeons in Australia and New Zealand on the subject of resection for pulmonary tuberculosis, with a specific request for opinions concerning thoracoplasty. A symposium was then held by the Royal Australasian College of Surgeons, and nearly all were agreed that thoracoplasty was an inferior form of treatment where pulmonary resection could be performed. The reviewer also quoted figures from the thoracic unit of an Australian teaching hospital in which the proportion of patients suffering from tuberculosis who had a thoracoplasty performed dropped from 93% in 1950 to 6·5% in 1957. He goes on to comment: "The type of disease which might be treated with thoracoplasty is disappearing, and the continued success of the programme to eradicate pulmonary tuberculosis from this and other countries will probably make all operations for pulmonary tuberculosis of historical interest in a few decades. The operation of thoracoplasty developed from the pioneer work of such European surgeons as Brauer, Friedrich, Wilms and Sauerbruch. After World War I the name of Alexander became associated with an operation which was more selective and his views gained wide acceptance in the U.S.A. In Scandinavia the names of Holst and Semb became associated with an operation that involved not only the removal of selected ribs, but they taught that the effect of this was considerably enhanced if the diseased lung was freed from its fascial connexions with the neck and mediastinum. Their views gained wide acceptance in England, but not in the U.S.A. Many American surgeons became dissatisfied with the results of thoracoplasty and some have almost abandoned the operation. I do not think my remarks dishonour the name of John Alexander, but the difference between the operation he popularized and the operation developed in Scandinavia is a very real one in relation to the results. Some surgeons and many physicians are unaware of this difference."—EDITOR.]

ANÆSTHESIA IN HEART DISEASE.

SIR: In his thoughtful paper on "Anæsthesia in Heart Disease" (M. J. AUSTRALIA, February 8, 1958) Dr. S. V Marshall says: "For the great majority of cardiac subjects general anæsthesia is preferable to local anæsthesia. . . . Local analgesia necessitates *heavy* (my italics) premedication to ensure quietude and to abolish emotional reactions. . . ."

I think that Dr. Marshall's rejection of local anæsthesia is too sweeping. Whether or not general anæsthesia is preferable for cardiac subjects depends not only on the nature of the operation, but also on the personality both of the patient and the surgeon, as well as on the type of heart disease from which the patient is suffering.

It is with Dr. Marshall's second statement that I beg to differ. Many of us who remember Dr. Cyril Corlette's pioneer work with local anæsthesia often disapproved of the heavy premedication that he used, and I recall many patients who required constant nursing and observation during hours of post-operative coma or semi-coma. Many modern anæsthetists seem to be perpetuating this heavy premedication which, I hold, is neither necessary nor desirable. A short time spent on instilling confidence into the patient will go a long way to assuring him that his operation will be painless and undisturbing. For the more nervous patients who still show doubt or apprehension, light hypnosis is invaluable not only for the operation itself but also for the post-operative period. Most people are susceptible to light hypnosis, and this light stage is sufficient for most purposes. From time to time, some patients will be found to pass easily into a deeper stage, and for these neither premedication nor local anæsthesia will be necessary. The great value of hypnosis in surgery was clearly shown by James Esdaile as far back as 1850 in his book "Mesmerism in India", which has lately been reprinted by the Institute for Research in Hypnosis as "Hypnosis in Medicine and Surgery" (1957, Julian Press, Incorporated, New York). In recent times we have the reports from R. Sampimon and M. Woodruff (M. J. AUSTRALIA, March 23, 1946) of their experience with hypnosis as a substitute for anæsthesia in a prisoner-of-war camp in Malaya. I have made tentative trials of hypnosis with varying success; e.g., I have performed three bronchoscopies under hypnosis only and several minor operations such as hernioplasty. With the cooperation of my colleague, Dr. George Davidson, a patient recently came to operation for pulmonary lobectomy with the usual premedication replaced by light hypnosis; this proved satisfactory to all parties. For further support of the value of suggestion and hypnosis there are many encouraging reports from obstetricians and dentists in their specialities. Finally, even when the usual premedication and anæsthesia are to be used, suggestion and hypnosis are very valuable in allaying the pre-operative (and pre-anæsthetic) fears and emotional upsets which, as Dr. Marshall has pointed out, are always deleterious.

The main objection that I have heard against is that it takes more time than most surgeons or anæsthetists can afford. As the patient's contact with the surgeon is more immediate and intimate than with the anæsthetist, it may well be that the role of hypnotist will fall primarily on the surgeon, who can then bring the anæsthetist into *rapport* with the patient through post-hypnotic suggestion. In any event there is no escape from the fact that time must be considered.

In putting in this plea for more use of suggestion and hypnosis, I do not for one moment consider that it can replace conventional anæsthesia for most patients. Moreover, one must be prepared for a certain number of failures. But of its great value I have no doubt.

Yours, etc.,

185 Macquarie Street, Sydney, February 14, 1958.

M. P. SUSMAN.

SUPERVOLTAGE RADIOTHERAPY.

SIR: On reading the letter from Dr. J. Cameron Loxton in the issue of your Journal dated February 8, 1958, I was sorry to see that his overseas peregrinations have resulted in such an unfavourable assessment of supervoltage radiotherapy.

My staff and I would be pleased to welcome Dr. Loxton at this Institute, and I feel confident that, if he is in any degree open-minded, his misapprehensions would be corrected.

Yours, etc.,

A. G. S. COOPER, Director.

The Queensland Radium Institute, Brisbane, Queensland. February 14, 1958.

PERINEAL TESTICLE.

SIR: I have read with great interest the account of a perineal testis by W. J. Sleeman (M. J. AUSTRALIA, February 8, 1958).

This condition is indeed rare, but not by any means as rare as might be supposed from the number of cases reported in the literature. In a series of over 150 cases of maldescended testes, encountered since the war, I have seen two cases of perineal testis, one of which has already been operated on, and no doubt all surgeons dealing with any large number of undescended testes see odd cases from time to time lying in the perineal position.

It used to be my opinion that, as Dr. Sleeman suggests, imperfectly descended testis was more common than ectopic testis; however, a careful check in each case in the series mentioned has shown that the great majority of testes which do not descend normally into the scrotum are ectopic rather than imperfectly descended. Very often it will be found that, although these testes may be lying freely movable in the so-called superficial inguinal pouch—the common

position for ectopic testis—a careful search during the dissection will show more often than not that a very definite gubernaculum can be demonstrated which passes, not as one would expect, towards the anterior superior spine, but definitely down into the tissues on the medial side of the thigh.

As Dr. Sleeman states, an ectopic testis is easier to place in the scrotum than an imperfectly descended one, but it is not correct to say that the cord is always of ample length in cases of ectopia; in the vast majority of cases of ectopic testis quite a considerable dissection is necessary, extending well up behind the posterior peritoneum, before the testis can be placed in the scrotum easily, without tension on the vas and the vessels.

Robert Gross is insistent that the most important step in the operation is a very extensive dissection upwards behind the peritoneum, with, at the same time, avoidance of the least damage to the spermatic vessels and the delicate blood supply of the vas itself.

Yours, etc.,

K. B. FRASER.

Ballow Chambers,
Wickham Terrace,
Brisbane.

February 14, 1958.

DUTCH DOCTORS FROM INDONESIA.

SIR: I support Dr. Scott-Young's suggestion (M. J. AUSTRALIA, February 1, 1958); we should offer these doctors openings in northern Australia where they are badly needed.

We should also give them, and other migrant professional folk, three months' experience of practice in association with local practitioners, during which interval we should teach them English with recordings and all the rapid language-teaching devices used for services personnel in wartime.

The standard of Dutch medicine is high, as I can testify from association with a Dutch medical practitioner, permitted to practise in New South Wales on recommendation of a university committee.

Yours, etc.,

DOUGLAS EVERINGHAM, M.B., B.S.

Rockhampton,
Queensland,

February 4, 1958.

HYPERCARBÆMIA.

SIR: Dr. Drummond, Dr. Simpson and Dr. Thomas are to be congratulated for drawing attention, in your issue of February 1, 1958, to the unsuspected development of hypercapnia in various circumstances. Their outline of the factors which may lead to its occurrence during anæsthesia is highly cogent, but the subsequent remarks do not stress adequately the fact that truly efficient pulmonary ventilation is the essential safeguard against this deleterious abnormality.

It is wrong to state that other writers almost universally ignore the condition—it has been the subject of quite frequent comment in many articles that have appeared over the past 10 or 15 years. Further, to say that closed-circuit anæsthesia has been largely abandoned because of its excessive dangers is nonsense. This technique is indispensable in most upper abdominal and all intrathoracic operations, as well as in many others in which the relaxing agents are employed. Any dangers are due mainly to its incompetent use.

A better general appreciation is required of the fact that a gaseous mixture delivered at the respiratory orifices cannot, even with an endotracheal tube in place, ensure proper lung ventilation when spontaneous breathing is depressed. Obviously, when this is paralysed, not even a hurricane flow can be effective unless deep endotracheal insufflation is practised. There is no question that properly aided or controlled respiration, which recourse to the closed circuit will really provide, is imperative in such circumstances.

Nevertheless, the writers have exposed a defect frequently noticeable in current practice, a defect that the comparatively "closed circuit" of anæsthetic literature has so far been unable to correct.

Yours, etc.,

S. V. MARSHALL.

"Harley",
143 Macquarie Street,
Sydney.

February 10, 1958.

Obituary.

ETHEL BYRNE.

WE are indebted to Dr. Marjory Little for the following account of the career of the late Dr. Ethel Byrne.

Ethel Byrne was the second youngest in a family of ten, the members of which formed a devoted unit. Her father was a country schoolmaster who encouraged higher education among his daughters, as is proved by the fact that three became qualified nurses, another was one of the first women to graduate in the Faculty of Agriculture, one trained as a teacher, and one became a member of the medical profession.

Ethel Byrne was educated at the Maitland High School, from which she entered the Faculty of Medicine with an exhibition. She graduated in 1918 at the University of Sydney, and after holding a resident post at the Royal Newcastle Hospital she decided to specialize in clinical pathology. She established a successful private practice in Newcastle and acted as honorary pathologist to the hospital; but even during this period her love of clinical medicine found expression in the establishment of a chest dispensary, to which she gave devoted service for many years. In addition to the heavy demands of a private practice, Ethel Byrne made time to supervise the pathological services at the Cessnock, Kurri and Maitland Hospitals, and paid regular visits, often necessitating long hours of travelling, to these institutions. About ten years ago she gave up private practice to devote her whole time to the Royal Newcastle Hospital as staff physician and tuberculosis officer. She gained her Membership of The Royal Australasian College of Physicians in 1943.

I first became closely associated with Ethel Byrne in 1916, when she was selected as one of two fourth year medical

students to work in the pathology department of the Royal Prince Alfred Hospital. The demands of active service had greatly depleted the staff of this department, and the students gave such time as they could spare to helping to collect specimens from patients in the wards. It was here that Ethel Byrne revealed the qualities which were to endear her to all with whom she came in contact; it was here that a friendship which lasted till her death was established between us. I have vivid memories of a conversation between Ethel Byrne and her companion student which I overheard after they had been with me for a few days. The other student asked Ethel to run over the equipment she should have on the tray she was taking up to the wards. Ethel's unexpected, but most characteristic, reply came: "Courage, kindness, red cell fluid, white cell fluid, pipettes, etc." I like to think it was the months she spent with me at that time that, partly at least, decided her to specialize in clinical pathology; I am certain that the laboratory experience she gained during years of practice in clinical pathology played no small part in making her the sound physician she became.

Ethel Byrne's life was completely spent in unselfish service to others. Her recognition of her professional responsibilities, her devotion to family and friends, her help to those in need formed the pattern of her daily life. It will be difficult to replace her in the medical world of Newcastle, where she was universally beloved; she can never be replaced in the affections of those privileged to call her friend, for memories of her gentle, charming, unselfish personality will remain with us always.

DR. C. J. MCCAFFREY writes: From the time of her graduation until her death, Dr. Ethel Byrne had a continuous association with the Royal Newcastle Hospital.

She served as a resident medical officer, and then for a time as resident pathologist. On resigning to take up practice as a consulting pathologist, she was appointed to the visiting staff as honorary pathologist. She held this appointment for twenty years. Nearly thirty years ago, in addition to her usual activities, she undertook the direction of the chest dispensary in King Street, which was maintained by the Department of Public Health. Just over twenty years ago this was transferred to the recently completed outpatient block of the Royal Newcastle Hospital and became the forerunner of the present chest clinic of the hospital. Dr. Byrne moved with it and directed its activities until the day of her death. The work of the clinic increased to such an extent that in 1947 she agreed to forsake private practice and devote herself full time to the task. This was the more timely from a hospital viewpoint, as Rankin Park—a chest unit of 100 beds—was ready to be put into operation.

Not only did she guide the destinies of Rankin Park from its beginnings, but she lived to see completed and put into operation Byrne House, an adjunct to Rankin Park. This is a hostel for male patients suffering from tuberculosis. This was a project dear to her heart, for which she had worked for years.

From August, 1955, to August, 1956, she was abroad visiting Canada, the United States, Great Britain and Europe. The visit was sponsored by the Hospitals Commission of New South Wales in order that she could study recent developments in the treatment of tuberculosis.

There can have been few people who have given themselves so wholeheartedly to the course they have decided upon.

During her whole life she was a busy person; but during the last ten years she devoted herself to the care of her chest patients and others with a devotion which was quite remarkable. Her knowledge of each patient's physical condition was accurate and complete; but to this were allied an ability to evaluate the total situation in which the patient was involved, a practical interest in their welfare, and a knowledge of their circumstances which continually surprised. Over the years the number of her patients ran into thousands, and she managed to maintain contact with them all. Even when the load became impossibly heavy, it caused her distress that she should have to allow others to share it. Right to the end of her busy life she was at call to any one of her patients who sought her help. She was one of those very few people who give themselves selflessly to aid their less fortunate fellows. However, it is also true that she wanted no sympathy for the amount of work she performed and probably needed none, for she enjoyed all that she did. Her patients and her work were her life.

Her loss will be felt for long by those of us who were her colleagues. To many of her patients her loss will be irreparable, for of her it could truly be said, as was said of Osler, she was "the beloved physician".

WALTER CROSSE.

WE are indebted to Dr. W. H. B. Crosse for the following account of the career of the late Dr. Walter Crosse.

Walter Crosse was born in Liverpool, England, on January 31, 1887, and died in Brisbane on October 8, 1957. He was reared in Keswick, in the Lakes District of England, and in 1910 qualified L.R.C.P., L.R.C.S. at Edinburgh. For a short period he was assistant in a practice at Tadcaster, Yorkshire. He then became ship's surgeon on a vessel which traded along the west coast of Africa and up some of the larger rivers, such as the Congo. After this he joined another ship going to China and Japan, and on the way home, owing to a coal strike, the ship was diverted to Australia. Immediately on his return to England he made arrangements to migrate to Australia, which he did in 1912.

On his arrival in Melbourne, he acted as a *locum tenens* in St. Kilda for a short period and then commenced practice

in Murwillumbah, in New South Wales. Towards the end of 1912 he married Miss Gladys Burnham. He remained in Murwillumbah until the last year of the 1914-1918 war, when he joined the Australian Imperial Force and served with the Light Horse in the Middle East. Before demobilization he obtained leave without pay, and was given an interim appointment in the ear, nose and throat department of the Edinburgh Royal Infirmary, and obtained his Fellowship of the Royal College of Surgeons of Edinburgh in 1919.

On his return to Australia he bought a practice in the specialty of ear, nose and throat in Brisbane, practising first in George Street and then in Wickham Terrace.

In 1921 he joined the honorary staff of the Hospital for Sick Children, Brisbane, and later became senior ear, nose and throat surgeon at the Brisbane General Hospital. He retired from this position in 1946, and was appointed honorary consultant surgeon. In 1928 he was made a Fellow of the Royal Australasian College of Surgeons, and when the Medical School opened in Queensland he became the first lecturer in diseases of the ear, nose and throat. During the 1939-1945 war he was ear, nose and throat consultant to the 112th Australian General Hospital, from its embryonic days at the Brisbane Showgrounds to the days when it was well established at the site of the present Repatriation General Hospital at Greenslopes. At the same time he continued in private practice and at the Brisbane General Hospital. Ill health forced his retirement at the end of 1953. He is survived by his widow and one son.

From early childhood Walter Crosse was interested in everything mechanical, and his school work suffered in consequence. Throughout his school days he shared the bottom of the class with two others; but when he was once embarked on the medical course he revelled in it, and at one stage won a prize in the subject of mental illness. The prize consisted of three months' board and lodgings in the Larbert Asylum, and while he was there he extracted the teeth of over half the 2000 inmates, as the superintendent believed in the theory of septic foci. The skill thus acquired stood him in good stead in latter days before the advent of oral surgeons.

As a boy he generated electricity by utilizing a spring on his father's property to turn a turbine, and this electricity was used to operate a bell-ringing system in the Keswick home. These bells are still *in situ*. He had a motor-car before he had furniture. His model T Ford was equipped with interchangeable wheels before this luxury was on the markets. Redesigning a steam car in the early 1920's absorbed a great deal of his time, and this was superseded by an intense interest in wireless. Many of his colleagues' radios were designed and built by him, and he is credited with making the first public address amplifier in Queensland. He recognized the importance of oscillations in the old wireless sets, but his attempts to control and calibrate these were unsuccessful. Even when handicapped by Parkinsonian degeneration, he managed to manufacture a tape recorder. Needless to say, this mechanical trait was evident in his professional work, and it was largely due to his efforts that sucking machines were installed in the Brisbane Hospital.

The specialty of ear, nose and throat used to cover a far greater field than it does today; without the modern ancillary services manual dexterity was most essential, and it is in this regard that Walter Crosse was outstanding. He had limitless energy and enthusiasm for any subject in which he was interested, and it was often difficult for a listener to get away from "Crossie" when he was "wound up". Apart from his personal skill, Walter Crosse is perhaps best remembered for his untiring efforts to help his juniors; small study groups were a not infrequent feature of his home life, and quite a few resident medical officers performed their first mastoidectomies in the workshop. I recall witnessing a successful cataract extraction performed on a goldfish.

Basically Walter Crosse was a very shy man, and only a few of his friends were aware that as a youth he was quite a good swimmer, and as a young man was a member of a first-class amateur theatrical company. Because of his shyness his publications were few; but the article on atypical mastoiditis is still worth reading.

SIR ALEXANDER MURPHY writes: I first knew Walter Crosse when we both commenced practice in Brisbane in 1920 after returning from World War I, and then were laid the foundations of our professional association and personal friendship which lasted until his retirement, and later his death.

He might well have been called the Chevalier Jackson of Australia, for I believe that he was the first to use a mechanical sucker in ear, nose and throat work, and also pioneered recovery of inhaled foreign bodies with the bronchoscope. His skill with the guillotine was unequalled, and had he been able to handle the pen with a fraction of the facility with which he wielded his instruments, his name would have been known beyond the confines of Australia. No one exhibited greater conscientiousness in public hospital or private practice, and his motto "do it today" saved many a life.

His mechanical genius and manual dexterity were amazing, and he was a master of that difficult instrument the lathe. His colleagues still use wireless sets, transformers and bronchoscopes of his making, and at one time when poultry farming was a passing interest, he fashioned the thermostats for the incubators, considering the ready-made article less reliable.

A staunch and loyal friend of many, he will long be remembered in the community.

WILLIAM JOHNSTONE BINNS.

WE are indebted to Dr. W. F. Simmons, Mr. K. Binns and Dr. George Bell for the following account of the career of the late Dr. William Johnstone Binns.

William Johnstone Binns was born on October 26, 1878, at Dumfries, Scotland (the birthplace of Sir T. P. Anderson Stuart, founder of the medical school of the University of Sydney). He was the son of the Reverend Frederick Binns, a well-known Congregational minister, who came to Australia with his wife and four sons in 1890. William Johnstone Binns received part of his education at Sydney Grammar School. After leaving school he entered the Faculty of Arts at the University of Sydney, and graduated M.A. in 1902 with honours in philosophy and English. This he did as an evening student, while holding the position of assistant librarian in the University library. During these four years he was closely associated with the formation of the Evening Students' Association, and was its representative on the editorial staff of *Hermes*. From arts he proceeded to medicine, retaining his association with the library, but this time as evening librarian. Having graduated M.B. in 1907, he was appointed a junior resident medical officer at Sydney Hospital in that year and stayed on as a senior in 1908. On leaving Sydney Hospital he was appointed a resident medical officer at the Women's Hospital, Crown Street, after which

he held a number of positions as *locum tenens* in Queensland. He returned to Sydney, and after a time spent in general practice in Rockdale, in 1910 he became assistant and later partner to Dr. J. J. O'Keefe, of Kogarah. In 1914 Dr. O'Keefe gave up contract practice and confined his work mainly to surgery. Binns took over the general practice, and invited the late Dr. Wilfred White to join him. This partnership lasted until the death of Dr. White in 1938. During this period Dr. White did most of the surgical work, while Binns did the medical and obstetric work. In obstetrics he was expert, and had a large practice. It was not surprising that in 1925, when the honorary medical staff of the St. George Hospital began to divide itself into physicians, surgeons and obstetricians, Binns should be appointed the first senior honorary obstetrician at the hospital, and he continued in this position for some years. At the last annual meeting of the Illawarra Suburbs Medical Association, it was decided to award a prize in obstetrics in his memory to the most proficient trainee nurse graduating in midwifery nursing.

In 1916 Binns enlisted in the first Australian Imperial Force, and went overseas with the 9th Field Ambulance under the late F. A. Maguire. Early in 1917 he was appointed senior medical officer to the troopship *Benalla*, and was attached to the 33rd Battalion under the command of Lieutenant-Colonel (now Sir) Leslie Morshead, who regarded him as an outstanding regimental medical officer, "right out in front". This battalion took part in the attack on the Hindenburg Line, which broke through the enemy's defences and led to their final defeat. During this fighting Binns was awarded the Military Cross for "bravery in action". As he was a fluent French scholar, he was frequently used by the army as an interpreter. Perhaps, then, it was natural that he should marry Mademoiselle Francisca Sigarol, whom he met while serving in France.

After the death of Dr. White in 1938, Binns continued on in practice single-handed for a number of years; but in 1946 he found the task too much, and was assisted by Dr.

J. S. Quill. A series of bouts of acute illness forced him to retire in 1952, but he still continued to live in his old home, while Dr. Quill carried on the practice elsewhere.

In his youth Binns was a keen footballer, runner and boxer. He frequently acted as referee in army contests, and even played for his battalion in the inter-battalion football contests when the war ended. During the whole of the second World War he acted as honorary correspondent of the Illawarra Suburbs Medical Association to all its members on overseas service, and his amusing and informative letters were greatly appreciated. His greatest interests were the study and practice of medicine and the reading of French literature, of which he had an extensive library.

Binns never spared himself in his practice, and his patients and colleagues loved him. He was a charming host, and his friends were legion. He represented all that was highest and best in general practice.

DR. A. C. THOMAS writes: There have been vast changes in the practice of medicine during the past fifty years. General practice seems to have altered completely, and the typical old family doctor is fast disappearing. Dr. William Johnstone Binns, who died recently, was one of these, and on many occasions in conversation with him he deplored this modern era and could not reconcile himself to it. He graduated in medicine in 1907. Five years previously he had gained his M.A., and he retained his interest in literature and languages throughout his life. His great recreation was reading French novels. He was quite fluent in this language, and retained his interest in France and her people. In all this he was greatly helped by his devoted wife, whom he married in France in 1919, after World War I.

Dr. Binns first commenced practice in Rockdale in 1910, but soon afterwards became associated with the late Dr. J. J. O'Keefe in Kogarah. The amount of work this partnership did was astounding. In those days the lists of lodge patients ran into thousands, and the calls demanded were many. Hours of recreation were very few. It was his custom, when doing the very large "surgeries" of those days, after working for a few hours, to retire to his piano player or his tennis court for twenty or thirty minutes, and then continue on his consulting. When Dr. O'Keefe retired from friendly society practice, Dr. Binns became a partner with the late Dr. W. J. White, and this partnership lasted until the latter's death in 1938. After this he practised on his own account. During all these strenuous years, relieved only by some years of service in war, during which he was awarded the M.C., Dr. Binns always maintained an equable temperament and never spared himself in helping his patients. They were his first consideration always. He regarded his work as a vocation, and he felt that recent trends in practice were detrimental to this approach. It was this that irked him so.

As a physician on the St. George Hospital he gave loyal and devoted service, while his experience in practice had made him a most competent obstetrician. He took a great interest in the affairs of the British Medical Association, and for a period was a member of the New South Wales Branch Council. Those members of the Illawarra Suburbs Medical Association who were on service during the last World War will ever be grateful to him for the witty, brilliant and informative newsletters which arrived regularly from him.

Dr. Binns was the representative of a type of practitioner which, as a result of modern practice and increased medical knowledge, is ceasing to exist. However, these men built up a tradition of service which it is to be hoped will never be lost, and Dr. Binns was a worthy member of this company.

Hospitals.

ROYAL PRINCE ALFRED HOSPITAL, SYDNEY.

VISIT OF DR. H. T. BAHNSON AND DR. R. SPENCER.

WHEN Sir Edward Hallstrom, of Sydney, visited Dr. Alfred Blalock at the Johns Hopkins Hospital, Baltimore, U.S.A., in 1956, he met Dr. Henry T. Bahnson, who had just begun to work on the extracorporeal circulation at that institution. He at once invited Dr. Bahnson to visit Sydney later in the year, at Sir Edward's expense, and to demonstrate his work at the Royal Prince Alfred Hospital. Dr. Bahnson gladly accepted the invitation, but as the techniques and equipment were still in a state of flux, he wisely decided to defer his journey to Australia until a satisfactory by-pass pump was in commercial production, and until he and his assistant, Dr. R. Spencer, had achieved sufficient experience with such apparatus.

After the development of the Marks pump and surface oxygenator, and a considerable and successful series of operations at the Johns Hopkins Hospital, Dr. Bahnson announced his readiness to visit Sydney, in company with Dr. Spencer, and suggested that a complete duplicate equipment with which he had worked should be purchased in the United States and air-freighted to Sydney before his arrival. This equipment included the Mark G.K. pump, oxygenator, cannulæ, monitoring devices and resuscitation apparatus—an expensive outlay. At this point Mr. and Mrs. C. M. Fox and the New South Wales Hospitals Commission came forward with funds to permit of its purchase, so that when Dr. Bahnson and Dr. Spencer arrived, the whole of the instruments were already set up and in working order. The American surgeons began at once to put them to work and to try their efficiency on laboratory animals. Having satisfied themselves that everything was in good working order and that the animals survived the by-pass, they proceeded to operate on their first patient.

Altogether twelve patients were operated upon by the visitors, as follows: atrial septal defect, three patients; ventricular septal defect, five; congenital aortic stenosis, one; total anomalous venous damage, one; infundibular pulmonary stenosis, one. There was no mortality. Eight of the patients required the extracorporeal by-pass, and hypothermia with coronary perfusion was used in the remainder. Full details of these patients, and of those since operated upon by members of the surgical staff of the Royal Prince Alfred Hospital, will be presented at the meeting of the Cardiac Society of Australia and New Zealand in June, and subsequently published in the Australian medical Press. A further programme of operations using the Mark pump has now commenced at the Royal Prince Alfred Hospital.

It became apparent at once that this type of work required a large team which must be fully experienced and coordinated, and the visiting surgeons received the fullest cooperation from physicians, anæsthetists, resident medical officers, nursing staff, laboratory and instrument technicians as well as the hospital engineer and his assistants. In fact some 20 individuals, both lay and medical, were directly concerned with each operation at one stage or another. Dr. Bahnson and Dr. Spencer were given the highest priority in all their requirements and appreciated the devotion and cooperation which was theirs on every hand. They themselves set a high standard in the same direction. The Red Cross Blood Bank played their usual monumental role in the organization. Dr. Bernstein and Dr. Cartmill acted as registrars to Dr. Bahnson.

Dr. Bahnson remained over one month at the Royal Prince Alfred Hospital, and took part in a number of post-graduate discussions and lectures. He and Dr. Spencer left behind them a high reputation for unselfish devotion to the patients chosen for them, and were subsequently elected as honorary consulting surgeons to the hospital.

The events of the operating theatre were televised and reproduced in several sections of the Page Chest Pavilion, Royal Prince Alfred Hospital, through the courtesy of Amalgamated Wireless (Australasia) Limited. A number of visitors from other Sydney hospitals and from other States attended by invitation.

Research.

AUSTRALIAN ROUSSEL RESEARCH FELLOWSHIP AWARDED.

THE Australian Roussel Research Fellowship in the Department of Chemical Pathology, King's College Hospital Medical School, London, has been awarded to Dr. J. M. Greenaway, of Sydney. Dr. Greenaway will take part in a programme of research into the metabolism of adrenal steroid hormones using radioactive techniques.

The regulations for the Fellowship are as follows: (i) The Australian Roussel Research Fellowship was established in 1957 under an agreement between Roussel Laboratories, Limited, London, and King's College Hospital Medical School. (ii) The income provided for under the agreement is intended to meet the cost of a Fellow for research work in the field of adrenal steroids and metabolites, and provides for the

salary of the Fellow as well as for apparatus and materials required by him in the prosecution of his research work. (iii) The holder shall be called the Roussel Fellow, and he shall be a suitably qualified worker from Australia. (iv) The Fellowship shall be advertised and the appointment made by the Council of the Medical School upon the recommendation of the Academic Board, which shall be advised on the appointment by a committee nominated by the Academic Board. (v) The Fellowship is tenable for one year in the first instance, but may be renewed up to a maximum of three years. (vi) The salary will be at the rate of £1200 *per annum*. The Fellowship does not normally carry superannuation benefits, but if the person appointed is already a member of a superannuation scheme the employer's proportion will be met by the school up to a maximum of 10% of the gross salary. (vii) The Roussel Fellow shall work under the direction of the Professor of Chemical Pathology in King's College Hospital Medical School, London. (viii) The appointment shall be full time. Leave of absence with pay will be granted for six weeks during each year. (ix) The cost of the Fellow's return fare from Australia will be paid in advance by Roussel Laboratories, Limited, London.

Australian Medical Board Proceedings.

QUEENSLAND.

THE following have been granted limited registration, pursuant to Section 20 (3) of *The Medical Acts*, 1939 to 1955, of Queensland: Ionescu, Ion, Doctor of Medicine and Surgery, 1947 (Univ. Bucharest, Roumania); Acheson, Thomas Frederick, M.B., B.S., 1957 (Univ. Melbourne); O'Collins, James Patrick, M.B., B.S., 1957 (Univ. Melbourne); Turner, Bernard Godfrey, M.B., B.S., 1958 (Univ. Sydney); Ryan, Peter James, M.B., B.S., 1958 (Univ. Sydney).

The following have been registered, pursuant to the provisions of Section 19 (1) (*a*) and (*c*) of *The Medical Acts*, 1939 to 1955, of Queensland (the qualification, unless otherwise stated, is M.B., B.S., 1956 (Univ. Queensland)): Lithgow, David Roy; Cave, Frank Maurice; Whitchurch, Charles Walter; Rainnie, Ronald George; Casey, John Howard; Pegg, Stuart Phillip; Simpson, David Graham; Thrift, Errol George; Payne, Dorothy Barbara; Unwin, John Robertson; Cleary, Judith Ann; Andonov, Nikola Dimitrijevic; Backstrom, David Leon; Carroll, Kenneth John; Claxton, Colin James; Gallagher, Andrew Godfrey Patrick; Hurley, William Patrick James; Sheil, Ainslie Glenister Ross; Waller, John Powell; Forrest, David James; O'Dwyer, Patrick Francis; O'Neill, John Michael; Buchanan, Thomas Blair; Chong Wah, George; Todd, Bryan Edmund; Cheong, Mervyn; McCaffrey, John Francis; Hurst, Ronald Gordon; Leung, Wai Piu; Thomson, Ronald Leslie.

The following has been registered, pursuant to the provisions of Section 19 (1) (*b*) and (*c*) and Section 19 (2) and (6): Misso, Neril Emiliani, L.M.S., 1938 (Ceylon Medical College).

The following have been registered, pursuant to the provisions of Section 19 (1) (*a*) and (*d*): Wagner, Margaret Beryl, M.B., B.S., 1945 (Univ. Durham), M.R.C.O.G., 1951: McLeod, John Taylor, M.B., B.S., 1953 (Univ. Sydney), D.Obst., R.C.O.G., London, 1956; Knyvett, Suzette Maldon, M.B., Ch.B., 1951 (Univ. Leeds), M.R.C.P., London, 1953.

The following additional qualifications have been registered. Johnson, Horace William, M.R.A.C.P., 1946, F.R.A.C.P., 1957; Eckert, John Paul, M.R.C.P., Edinburgh, 1957.

Congresses.

SECOND INTERNATIONAL SYMPOSIUM ON FREEZING AND DRYING.

THE Institute of Biology announces that it is organizing the second International Symposium on Freezing and Drying, to be held in London on April 1 and 2, 1958. The conference is organized into four sessions, each session under the chairmanship of one of the following: Dr. A. S. Parkes, Dr. E. W. Flosdorf, Dr. S. T. Cowan, Professor R. W. Rycroft. The speakers include Professor B. Luyet (U.S.A.), Dr. H. T. Meryman (U.S.A.), Dr. P. Mazur (U.S.A.), Dr. C. Polge and Dr. M. A. Soltys (U.K.), Professor N. Kalsbukhov (U.S.S.R.), Dr. Y. Obayashi (Japan), Dr. P. W. Muggleton (U.K.), Dr. G. R. Scott and Mr. C. S. Rampton (Kenya), Dr. R. I. N. Greaves (U.K.), Professor Tokio Nei (Japan), Mr. T. W. G. Rowe and Mrs. E. Robson (U.K.), Dr. J. L. Stephenson (U.S.A.), Professor L. R. Rey (France), Dr. A. S. Parkes (U.K.), Professor D. Grieff (U.S.A.), Dr. B. L. Brady (U.K.), Commander G. W. Hyatt, M.D. (U.S.A.), Professor C. G. Rob (U.K.), and Dr. H. A. Sissons and co-workers (U.K.).

Admission to this meeting is free, and application for programme and tickets should be made to the Institute of Biology, 41 Queen's Gate, London, S.W.1.

Notice.

UNESCO SURVEY OF LABORATORY ANIMALS.

AT a meeting of consultants called by UNESCO in Paris during December, 1956, there was general agreement that a body should be formed to assist in solving problems arising from the increasing use of laboratory animals. As a result, an International Committee on Laboratory Animals has been set up under the auspices of the International Union of Biological Sciences, the Council for International Organizations of Medical Sciences and UNESCO.

As a first step, the International Committee on Laboratory Animals decided that a special survey should be carried out in as many countries as possible in order to determine the existing position in regard to the breeding, holding and use of laboratory animals, and surveys have already been completed or are in progress in the United Kingdom, United States of America, France, the Benelux countries, the Scandinavian countries, Switzerland, Italy, India and Japan.

I have been asked by UNESCO to carry out a similar survey in Australia. This will consist of two parts; the first is the completion of a short and simple *questionnaire*, while the second involves the personal visit of a veterinary pathologist assisting me in this project—Mr. Miles Pulsford, who is particularly interested in all problems connected with laboratory animals. It is proposed that he should visit all States during April and May.

As a preliminary step, a circular has been sent to a large number of laboratories throughout Australia inviting cooperation. The response has been most gratifying. It is, however, likely that a few laboratories that maintain or use laboratory animals have been overlooked, and it would be greatly appreciated if any such laboratories would inform me. Even should the number of animals purchased or bred be very small or only occasional, a reply will be appreciated.

ORDE POYNTON,
Director, Institute of Medical and Veterinary Science, Frome Road, Adelaide, South Australia.

CENTRAL COUNCIL FOR HEALTH EDUCATION.

THE Central Council for Health Education will hold an International Seminar on Health Education in London from April 22 to 25. It is being held in the week immediately preceding the Congress of the Royal Society of Health for the convenience of delegates from abroad who may wish to attend both meetings.

The programme is designed to cover the philosophy and practice of health education. It will be conducted by theoretical lectures, group discussion, and practical demonstrations of technique, and should give participants a rapid overall view of contemporary developments in the field of health education. Guidance will be given to delegates in planning programmes of health education to meet local needs in their own areas.

Further information may be obtained from the Medical Director, The Central Council for Health Education, Tavistock House, Tavistock Square, London, W.C.1.

SOCIETY FOR CLINICAL SCIENCE.

THE first meeting for 1958 will be held in the Maitland Lecture Theatre, Kanematsu Institute, Sydney Hospital, at 7.15 p.m., Monday, March 3. The speakers will be Dr. H. M. Whyte and Dr. K. D. G. Edwards (Clinical Research Department, Sydney Hospital), and the subject will be "Clinical Biochemistry and Renal Disease". Dr. B. D. Stacy will be in the chair.

DISEASES NOTIFIED IN EACH STATE AND TERRITORY OF AUSTRALIA FOR THE WEEK ENDED FEBRUARY 1, 1958.[1]

Disease.	New South Wales.	Victoria.	Queensland.	South Australia.	Western Australia.	Tasmania.	Northern Territory.	Australian Capital Territory.	Australia.
Acute Rheumatism	4	1(1)	10	..	..	..	..	..	15
Amœbiasis	..	..	..	..	..	..	..	..	..
Ancylostomiasis	..	..	..	..	..	..	2	..	2
Anthrax	..	..	..	..	..	..	..	..	..
Bilharziasis	..	..	..	..	..	..	..	..	..
Brucellosis	1	2	..	..	..	..	..	..	3
Cholera	..	..	..	..	..	..	..	..	..
Chorea (St. Vitus)	..	..	..	..	..	..	..	..	..
Dengue	..	..	..	..	..	..	..	..	..
Diarrhœa (Infantile)	3(3)	11(7)	7(6)	..	1	1	2	1	26
Diphtheria	1(1)	..	..	..	1(1)	..	..	..	2
Dysentery (Bacillary)	..	1	1(1)	..	5(2)	..	..	..	7
Encephalitis	..	2(2)	..	..	..	..	..	..	2
Filariasis	..	..	..	..	..	..	..	..	..
Homologous Serum Jaundice	..	..	..	..	..	..	..	..	..
Hydatid	..	..	..	..	..	..	..	..	..
Infective Hepatitis	23(11)	19(10)	21	2(1)	11(2)	..	..	..	76
Lead Poisoning	..	..	..	..	..	..	..	..	..
Leprosy	..	..	..	..	..	..	..	..	..
Leptospirosis	..	..	1(1)	..	..	..	..	..	1
Malaria	..	..	1(1)	..	..	..	..	..	1
Meningococcal Infection	..	2(2)	..	..	..	..	..	..	2
Ophthalmia	..	..	..	..	1	..	..	..	1
Ornithosis	..	..	..	..	..	..	..	..	..
Paratyphoid	..	..	..	..	..	..	..	..	..
Plague	..	..	..	..	..	..	..	..	..
Poliomyelitis	1	1(1)	..	..	..	..	..	..	2
Puerperal Fever	..	..	1	..	..	..	..	..	1
Rubella	..	31(22)	1(1)	8	20(20)	..	..	1	61
Salmonella Infection	..	..	..	..	..	..	..	..	..
Scarlet Fever	6(3)	6(5)	4(1)	..	2(2)	1(1)	..	..	19
Smallpox	..	..	..	..	..	..	..	..	..
Tetanus	..	..	1(1)	..	..	..	..	..	1
Trachoma	..	..	..	..	..	..	..	..	..
Trichinosis	..	..	..	..	..	..	..	..	..
Tuberculosis	55(30)	9(5)	10(7)	1(1)	4(3)	5	1	..	85
Typhoid Fever	..	..	..	..	..	..	..	..	..
Typhus (Flea-, Mite- and Tick-borne)	..	..	..	..	..	..	..	..	..
Typhus (Louse-borne)	..	..	..	..	..	..	..	..	..
Yellow Fever	..	..	..	..	..	..	..	..	..

DISEASES NOTIFIED IN EACH STATE AND TERRITORY OF AUSTRALIA FOR THE WEEK ENDED FEBRUARY 8, 1958.[1]

Disease.	New South Wales.	Victoria.	Queensland.	South Australia.	Western Australia.	Tasmania.	Northern Territory.	Australian Capital Territory.	Australia.
Acute Rheumatism	..	..	2(1)	..	..	..	1	..	3
Amœbiasis	..	1(1)	..	..	..	..	..	..	1
Ancylostomiasis	..	..	..	..	..	..	5	..	5
Anthrax	..	..	..	..	..	..	..	..	..
Bilharziasis	..	..	..	..	..	..	..	..	..
Brucellosis	1	1(1)	..	..	..	..	..	..	2
Cholera	..	..	..	..	..	..	..	..	..
Chorea (St. Vitus)	..	2(2)	..	..	..	..	..	..	2
Dengue	..	..	..	..	..	..	..	..	..
Diarrhœa (Infantile)	..	11(9)	2(2)	..	..	..	2	..	15
Diphtheria	..	1	..	..	1(1)	..	..	..	2
Dysentery (Bacillary)	..	2(2)	1	..	5(3)	..	7	..	15
Encephalitis	..	..	..	..	..	..	2	..	2
Filariasis	..	..	..	..	..	..	..	..	..
Homologous Serum Jaundice	..	..	..	..	..	..	..	..	..
Hydatid	..	..	..	..	..	..	..	..	..
Infective Hepatitis	30(19)	9(6)	8(2)	2(2)	16(1)	..	2	..	67
Lead Poisoning	..	..	..	..	..	..	..	..	..
Leprosy	..	..	1	..	..	..	..	..	1
Leptospirosis	..	..	..	..	..	..	..	..	..
Malaria	..	..	1(1)	..	..	..	2	..	3
Meningococcal Infection	..	1(1)	..	1(1)	..	..	..	..	2
Ophthalmia	..	..	..	..	..	..	..	..	..
Ornithosis	..	..	..	..	..	..	..	..	..
Paratyphoid	1(1)	..	..	..	..	..	..	..	1
Plague	..	..	..	..	..	..	..	..	..
Poliomyelitis	..	..	..	..	..	..	..	..	..
Puerperal Fever	..	..	1	..	..	..	..	..	1
Rubella	..	14(9)	2(2)	20(1)	14(12)	..	..	..	50
Salmonella Infection	..	..	..	..	3(3)	..	..	..	3
Scarlet Fever	12(9)	10(8)	..	..	2(2)	..	..	1	25
Smallpox	..	..	..	..	..	..	..	..	..
Tetanus	..	..	..	..	..	..	..	..	..
Trachoma	..	..	..	..	2(1)	..	1	..	3
Trichinosis	..	..	..	..	..	..	..	..	..
Tuberculosis	27(17)	14(12)	19(13)	2(1)	9(6)	5(3)	2	..	78
Typhoid Fever	..	..	..	..	..	..	..	..	..
Typhus (Flea-, Mite- and Tick-borne)	..	..	..	..	..	..	..	..	..
Typhus (Louse-borne)	..	..	..	..	..	..	..	..	..
Yellow Fever	..	..	..	..	..	..	..	..	..

[1] Figures in parentheses are those for the metropolitan area.

Nominations and Elections.

THE undermentioned have applied for election as members of the New South Wales Branch of the British Medical Association:

Speechley, Ronald Alwyn, M.B., B.S., 1956 (Univ. Sydney), 5 Farnham Avenue, Punchbowl, New South Wales.

Castaldi, Peter Anthony, M.B., B.S., 1957 (Univ. Sydney), 19 Monash Parade, Dee Why, New South Wales.

Dagger, Victor Ross, M.B., B.S., 1956 (Univ. Sydney), 15 The Biltmore, Farrell Avenue, King's Cross, New South Wales.

Fraser, Donald Ivor Alexander, M.B., B.S., 1957 (Univ. Sydney), Mater Misericordiæ Hospital, Crow's Nest, New South Wales.

The undermentioned have been elected as members of the New South Wales Branch of the British Medical Association: Fraser, Rex Britnell (provisionally registered), M.B., B.S., 1958 (Univ. Sydney); Harpur, Michael Hunter (provisionally registered), M.B., B.S., 1958 (Univ. Sydney); O'Neil, Brian James (provisionally registered), M.B., B.S., 1958 (Univ. Sydney); Pang, Henry (provisionally registered), M.B., B.S., 1958 (Univ. Sydney); Taylor, Roger Ralph (provisionally registered), M.B., B.S., 1958 (Univ. Sydney); Bencsik, Albert Frank, M.B., B.S., 1957 (Univ. Sydney); George, Rena, M.B., B.S., 1957 (Univ. Sydney); Moriarty, John Gerard, M.B., B.S., 1957 (Univ. Sydney); Burke, Claire Agnes, M.B., B.S., 1956 (Univ. Sydney); Lucey, Maureen, M.B., B.S., 1956 (Univ. Sydney); Potts, John Gilroy, M.B., B.S., 1956 (Univ. Sydney); Powrie, Robert Malcolm, M.B., B.S., 1956 (Univ. Adelaide); Ryan, Douglas, M.R.C.S., L.R.C.P. (London), 1944; Sgouromallis, John, M.B., B.S., 1955 (Univ. Sydney); Sloane, David Rae, M.B., B.S., 1956 (Univ. Sydney); Thomas, Ernest Morris, M.B., B.S., 1953 (Univ. London); Wayland, Jill Pamela, M.B., B.S., 1956 (Univ. Sydney); Bagdonavicius, Irene, M.D., 1949 (Univ. Tubingen), registered in accordance with the provisions of Section 17 (1c) of the *Medical Practitioners Act*, 1938-1957; Eikens, Arnolds, M.D., 1935 (Univ. Riga), registered in accordance with the provisions of Section 17 (1c) of the *Medical Practitioners Act*, 1938-1957; Paviovic, Leopold, M.D., 1948 (Univ. Prague), registered in accordance with the provisions of Section 17 (1c) of the *Medical Practitioners Act*, 1938-1957; Petersons, Valdemars Vladislavs, M.D., 1943 (Univ. Riga), registered in accordance with the provisions of Section 17 (1c) of the *Medical Practitioners Act*, 1938-1957; Bogdan, Andrew, M.D., 1945 (Univ. Budapest), registered in accordance with the provisions of Section 17 (2) of the *Medical Practitioners Act*, 1938-1957.

The undermentioned have applied for election as members of the South Australian Branch of the British Medical Association:

Gunning, Julienne Elizabeth S., M.B., B.S., 1957 (Univ. Adelaide), 52 Bevington Road, Glenunga, South Australia.

Hobbs, William Harris, M.B., B.S., 1957 (Univ. Adelaide), 2 West Terrace, Beaumont, South Australia.

Muecke, David Sunter, M.B., B.S., 1957 (Univ. Adelaide), 1 View Road, Walkerville, South Australia.

Beare, James Hudson, M.B., B.S., 1957 (Univ. Adelaide), 44 Church Terrace, Walkerville, South Australia.

Mann, William Eric, M.B., B.S., 1957 (Univ. Adelaide), 3 Heathpool Road, Heathpool, South Australia.

Allan, John Brooker, M.B., B.S., 1957 (Univ. Adelaide), 88 Coombe Road, Allenby Gardens, South Australia.

May, John Colwyn, M.B., B.S., 1957 (Univ. Adelaide), 4 East Terrace, Kensington Gardens, South Australia.

Pickering, Trevor George, M.B., B.S., 1957 (Univ. Adelaide), 10 Stirling Street, Tusmore, South Australia.

Gale, Allen Ewart, M.B., B.S., 1957 (Univ. Adelaide), 10 Dequetteville Terrace, Kent Town, South Australia.

Parks, Veronica June, M.B., B.S., 1957 (Univ. Adelaide), Lady Hore-Ruthven Drive, Outer Harbour, South Australia.

Hollis, Yvonne, M.B., B.S., 1956 (Univ. Adelaide), 10 Molesworth Street, North Adelaide.

Mocatta, Frances Arkell, M.B., B.S., 1943 (Univ. Adelaide), 5 Osborne Street, Hackney, South Australia.

Corrigendum.

ON page 285 of this issue an error appears which we were unable to correct. In the second line of the third paragraph from the bottom in column two the word "aeral" should be "acral".

Deaths.

THE following deaths have been announced:

TURNBULL.—Henry Hume Turnbull, on February 11, 1958, at Toorak, Victoria.

CHAPMAN.—Clement Lorne Chapman, on February 13, 1958, at Sydney.

BAXTER.—James Morehead Baxter, on February 14, 1958, at Melbourne.

THOMSON.—Ronald Moginie Thomson, on February 15, 1958, at Croydon, New South Wales.

Diary for the Month.

MARCH 4.—New South Wales Branch, B.M.A.: Organization and Science Committee.
MARCH 5.—Western Australian Branch, B.M.A.: Branch Council.
MARCH 6.—South Australian Branch, B.M.A.: Branch Council meeting.
MARCH 7.—Queensland Branch, B.M.A.: General Meeting.
MARCH 11.—New South Wales Branch, B.M.A.: Executive and Finance Committee.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or Tavistock Square, London, W.C.1.

New South Wales Branch (Medical Secretary, 135 Macquarie Street, Sydney): All contract practice appointments in New South Wales.

South Australian Branch (Honorary Secretary, 80 Brougham Place, North Adelaide): All contract practice appointments in South Australia.

Editorial Notices.

ALL articles submitted for publication in this Journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given: surname of author, initials of author, year, full title of article, name of journal, volume, number of first page of the article. The abbreviations used for the titles of journals are those adopted by the Quarterly Cumulative Index Medicus. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors submitting illustrations are asked, if possible, to provide the originals (not photographic copies) of line drawings, graphs and diagrams, and prints from the original negatives of photomicrographs. Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary is stated.

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